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ABSTRACT

This paper presents the findings from a trip to England, Denmark, Sweden, and Holland which was designed to investigate how hospitals in these countries facilitate children's healthy development during the stress of hospitalization. The areas specifically discussed are: (1) initiating and reinforcing family involvement; (2) meeting children's need for play; (3) adapting space, furnishings, and designs for parent and play programs; and (4) financing and publicizing programs. Information about the activities and functioning of government agencies, volunteer, and consumer advocate groups in each country are also included. (JMB)

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PARENT PARTICIPATION AND PLAY PROGRAMS IN HOSPITAL PEDIATRICS IN ENGLAND, SWEDEN AND DENMARK

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PS008257

To The World Health Organization who granted me the honor and made possible my travel study; to the program arrangers who understood my mission and arranged introductions to people and programs who helped me learn about parent and play activities, and to the nurses, psychologists, play leaders, physicians, parents and patients who shared so generously their experience, enthusiasm, wisdom, time and energy, I wish to express my deep appreciation. I truly learned the meaning of "hands across the sea," and hope that, together, we may continue to work to improve the situation for young hospitalized children and their families.

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FOREWORD

My long standing concern with the need to involve parents and to incorporate play into the world of the pediatric hospital arises from a background on the faculty in Maternal Child Nursing at the University of California, San Francisco, after many years working with parents and children in nursery school settings. Work with students and staff nurses at UCSF to bring parents and play into our hospital uncovered difficulties that can block these two important activities.

Our work and study of the research showed clearly that many people share these concerns and are working to humanize the hospital environment by making it more family and child-centered. In particular, programs in England, Sweden, and Denmark suggested that innovations were available for importation to the United States. I therefore applied to WHO for a travel-study fellowship and happily was granted the opportunity to visit.

This report presents findings from that trip.

The itinerary covered three countries: England, Denmark and Sweden, with a brief excursion added on my own to Holland. As the three countries have similar social philosophies, I hoped to see the result of national priorities on hospital pediatrics. England was selected because so much of the impetus for family inclusion has come from the work of James and Joyce Robertson, John Bowlby, and Anna Freud.

In addition, I anticipated collecting ideas for new designs for playthings and furniture to accommodate parents. This very practical aspect has lots to do with parent invitation and acceptance in the hospital. A space-saving bed for parents can open the ward to parents where a hundred impassioned arguments fail.

After WHO funding was approved and before the visits, correspondence and counsel came from representatives of the Ministries of Health in the several countries as well as from James Robertson, Margaret Belson (then president of NAWCH) and others interested in helping to make the study fruitful. To them I express my sincere gratitude.

On the trip, representatives of Ministries explained the organizational structure of government agencies and their relationship to hospitals and to preventive health programs. Such interviews helped me understand the governmental philosophy relative to the hospitals. Additional time went to attending conferences and interviewing representatives of private groups active in advocacy for young children in the hospital. Hospital visits took up the remainder of the time. All the hospitals visited in England and Scandanavia had philosophies based on concern for the child's psychological well-being. No visits were made to institutions with weekly or twice weekly rigid visiting hours, although such programs still exist.

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INTRODUCTION

I believe that hospitalization can be a positive experience for the pediatric patient and his family. The child can learn how precious he is to his own family and to caring people in the hospital and community. He and his family discover strengths they may never have known they had. The crisis opens them to learning as at no other time. If the child's supports are adequate, the hospitalization can become an adventure with the patient emerging a triumphant hero.

On the other hand, deprived of emotional support, the child and his family may have an additional psychological burden placed on the already stressful physical problem, thus lowering their ability to cope. The child and the family may become overwhelmed and not only fail to improve despite the hospital's efforts to help, but may actually be damaged by the experience.

It is the responsibility of the professionals who are aware of the research around the subject of attachment and separation to inform parents of their importance to the child and to help them in their plans to stay. Otherwise, parents, especially those with low self-esteem, may feel intimidated and uncomfortable and take flight under the pretext that they are only in the way.

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PAN AMERICAN HEALTH ORGANIZATION

Pan American Sanitary Bureau, Regional Office of the

WORLD HEALTH ORGANIZATION

CERTIFICATE OF AWARD

This is to certify that

Carol Hardgrove

has been awarded a fellowship by the Pan American Health Organization to study

Family Centered Pediatric
Care Programs

in

United Kingdom, Denmark and
Sweden

for a period of

four weeks

Any courtesies and facilities granted during the period of this fellowship will be appreciated.

for ABRAHAM HORWITZ
DIRECTOR

Washington, D.C.
18 May 1972

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OBJECTIVES

1. To see how hospitals in some advanced countries facilitate children's healthy development during the stress of hospitalization by:

   Initiating or reinforcing family involvement.

   Meeting their need for play.

   Adapting space, furnishings and designs for parent and play programs.

   Financing and publicizing programs.

2. To study the activities and functioning of government agencies, volunteer, and consumer advocate groups.

3. To bring back ideas for use in the United States.

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ITINERARY

England

September 18 - 29, 1972

Monday, 18 September

Mrs. C.M.R. Mitchell, Hospital Nursing Officer
Miss M. Simpson, Nursing Officer - Research
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
London SE 1

Tuesday, 19 September

All day conference on "Role of Hospital Play Leaders"
Sponsored by the Hospital Liaison Committee
Hospital Centre
King Edward Hospital Fund for London
24 Nutford Place
London WIY2AA

Wednesday, 20 September

Interview with Mr. James Robertson, Tavistock Clinic
Tavistock Centre
Belsize Lane
London NW3

Visit to Great Ormond Street
London WCI
Interviews with Miss Jill Green, Play Coordinator and
Miss Virginia Newman, Wards A and B

Thursday, 21 September

Mrs. Susan Harvey, Save the Children Fund
29 Queen Anne's Gate
London SW

Representatives of National Association for Welfare of Children
in Hospital: Mrs. Margaret Belson, Chairman; Mrs. V. Southerland,
Secretary
7 Exton Street
London SEI, 8VE

Itinerary Continued
England

Thursday, 21 September
(continued)

James and Joyce Robertson at home.

Friday, 22 September

Miss M. Fraser, Nursing Officer, Planning
Euston Towers, Room 629
Euston NWI

Fulham Hospital
St. Dunston's Road
London

Monday, 25 September

Amersham General Hospital
Aylesbury, Bucks
Interviews with Matron Sister Daniel and Dr. Donald Garrow.
Observations and interviews with parents and children on the ward.

Tuesday, 26 September

Stoke Mandeville Hospital
Aylesbury, Bucks
Interview with Matron Sister Gilbert
Interviews with parents on the ward
Observations on the ward
Dr. Jane Grubbs, Pediatrician
Observation of nursery school program for children with developmental deviations and handicapping conditions.

Wednesday, 27 September

St. Mary's Hospital
Praed Street
London W2
Tour of rounds made through Paddington Area with mobile unit team.

Interview with Thomas Oppé, M.D., Medical Director
St. Mary's Hospital

Thursday, 28 September

Miss S. Earl, Public Health Nursing Officer
Miss R. Maguire, Public Health Nursing Officer
Discussion of Nursery Nurses and Nursery School Education, U.K.
Alexander Fleming House
Elephant and Castle
London SE

Denmark

October 2 - 6, 1972

Monday, 2 October

Briefing, The National Health Service, Nursing Division
Miss Maja Foget, Chief of Nursing Division
Miss Else Bagger, Public Health Nursing Division
Miss Elisabeth Rubner, Home Nursing Consultant
Dr. Harold Kreutzfeldt, Chief of the Division
1 St. Kongensgade
DK - 1264 Copenhagen K

W.H.O. Regional Office for Europe
Interview with Miss Dorothy Hall, Regional Officer for Nursing and Vera Fry Maillart, Ed.D.
Scherfigsvej 8
2100 Copenhagen Ø

Tuesday, 3 October

Copenhagen County Hospital, Glostrup
Ndr. Ringvej
2600 Glostrup
Interviews with Miss D. Clode Henningsen, Director of Nursing Service; Miss Westergaard, Head Nurse, Pediatric Department; Mrs. Else Rafn, Psychologist

Day long visits to children's units, hobby rooms, demonstrations of devices and areas used to teach children about management of diabetes; observations and visits to hobby room, school room and hospital sponsored day care center for staff members' children. Visit to drop in day care center for siblings or children of patients.

Wednesday, 4 October

University Hospital (Rigshospitalet)
Blegdamsvej 3
2100 Copenhagen Ø

Interview with Miss Elisabeth Pederson, Departmental Sister, Pediatrics.
Meeing with psychologists assigned to pediatric departments under leadership of Mrs. Kirsten Skinhoj, Psychologist.
Visits to wards and observations of play.

Visit to Day Care Center on hospital grounds for staff children.

Itinerary Continued
Denmark

Wednesday, 4 October
(continued)

Visit to BRIS headquarters and interviews with volunteers.
Borns rettigheder i samfundet
Fredericiagade 15
1310 Copenhagen

Visit with Dr. Torben Bille and his wife at their home regarding programs in Denmark to encourage early family bonding, and the aims and objectives and accomplishments of BRIS.

Thursday, 5 October

Interview with Bitten Poelsen, Principal Nursing Officer, Frederiksborg County
Frederiksborg Amtsgaard
Kongens Vange
3400 Hillerod

Lunch, interviews and observations at Frederiksborg County Central Hospital

Mrs. Hanne Vesterdal Jorgensen, Head Nurse Pediatric department.
Tour of patient areas, playrooms, hospital day care center.
Visit with Mrs. Vesterdal and her husband, a physician at the hospital, in their apartment on the hospital grounds.

Dinner at Miss Poelsen's with a group of nurses fro Africa, Turkey, Greece, U.S.A., and Malaya.

Friday, 6 October

Hospital for Mentally Retarded Children
Bornehospitalet, Vangede
Sogneve j 40,
2820 Gentofte

Tour of facilities and grounds, including exposure to exciting adventure playground.

Visit to Bispebjerg Hospital, Miss Ellen Christensen, Director of Nursing Service
Interview with Child Psychiatrist attached to the hospital's psychiatric clinic.

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Sweden

October 9 - 13, 1972

Monday, 9 October

The National Board of Health and Welfare, Division of Information and International Cooperation.

Interview with Mrs. Birgitta Bjork, Secretary, Swedish Committee on Foreign Health Workers; Nursing Section.
Drottningatan 71 D
Second Floor
Stockholm

Visit to Samariten Hospital.
Interviews with Miss Ulrica Spens, Play Therapist.
Observations and interviews.
Barnsjukhuset Samariten
Ringvagen 21
Stockholm

Tuesday, 10 October

Karolinska Hospital, Child Clinic
Interviews with Prof. John Lind, Chairman of Pediatrics; interview with Dr. Karin Stensland Junker, Department of Pediatrics.
Tour of Karolinska facilities for parents and for play.
Tour of Day Care Center for Karolinska employees' children.

Evening: Dr. and Mrs. Bjork entertained me in their home for dinner where I met Qui Nystrom of the Swedish Radio and her husband. I learned a great deal about recent research in Sweden on the subject of parents and hospitalized children.

Wednesday, 11 October

Stadshagsskolan (Nursing School)
St. Goran Hospital Child Clinic
St. Goransgatan 145
Stockholm

Mrs. Ulla Termmeden, Director of Studies...description of Swedish system of nursing education.

Lunch with nurse-nursery school teacher team for undergraduate preparation of Child Nursing program.

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Itinerary
Sweden

Wednesday, 11 October
(Continued)

Tour of St. Goran's Hospital with emphasis on parent quarters and play program.
Interview with Dr. Marcel d'Avignon, St. Goran's Hospital Child Clinic.

Tour of Rehabilitation facilities.

Thursday, 12 October

Day in Umea visiting Region's Hospital of Umea and interview with Mrs. Ivonny Lindquist and her staff.

Friday, 13 October

Return to Karolinska.
Visit to Lekoteket with Karin Stensland Junker.

Dinner with Dr. Junker at her home.

Trips to shops for special play equipment.

Holland

October 15 - 16, 1972

Sunday, 15 October

Brief visit and interview with pediatric resident,
University Hospital, Amsterdam.

Monday, 16 October

Interviews and Observations.
Queen Wilhelmina Hospital, Utrecht
Anthony P. Messer, Psychologist

Interviews and Observations.
Children's Hospital
University of Leiden
Discussion of program to prepare Observatrices.
Discussion of their activities.
Observations of wards and playrooms.

ENGLAND

GOVERNMENT POLICY

The official policy of the Ministry of Health in United Kingdom regarding children in the hospital is outlined in a document known as the Platt Report issued in 1959. The Platt Report followed the work of James and Joyce Robertson and Dr. John Bowlby at the Tavistock Clinic regarding the potential damage that could come about to children and their families due to the separation that hospitalization entails. The Ministry did not issue directives, but assumed a consultant role to the health care delivery system. However, hospitals that do follow Platt Report guidelines may be in a more advantageous position when new programs are assigned priorities.

The Platt Report advises hospitals to encourage parents to visit children at any reasonable hour, and to arrange accommodations for mothers (or fathers) whenever possible. It further recommends that children not be nursed in adult wards, or scattered throughout the hospital, but gathered into a children's unit. It specifically suggests that "all children's departments provide accommodation for mothers and possibly on occasion for fathers so that they may stay with their children during assessment, during acute illness and from time to time during long stay care. For every twenty children's hospital beds, there be at least four beds for parents, free of charge, and that there be additional parent lounge, bathing and kitchenette facilities."

Not all hospitals adhere to the Platt Report's suggestions, but it does serve as a guide. The hospitals I visited do conform.

GOVERNMENTAL GUIDELINES

In England, as in other countries, programs and attitudes toward play vary from hospital to hospital. In some institutions, play leaders fill children's days with play schemes. In others, play is neglected or is relegated to parents or to busy nurses. Standards are high; but salaries are low, so there are fewer play leaders than are needed or desired.

The National Health Service encourages play programs in hospitals. In memoranda to regional hospital boards, boards of governors, and hospital management committees NHS stresses that play is important and recommends the employment of nursery nurses to "organize and encourage play for children individually and in small groups." Ministry guidelines in the form of hospital building notes recommend design and equipment to adapt children's wards for play, with dayroom space adjacent to multi-bed children's wards on the ground floor whenever possible, to allow access to outdoor play yards equipped with sand boxes, swings, and climbing frames (when ground floor wards are not possible, the Ministry advises that roofs and balconies be used for play yards in addition to play space on the grounds).

At least thirty square feet of floor area per patient bed is suggested to be

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used for play, television, exercise, dining, school work, and parent-child play. Recommendations are specific as to kinds of toys, storage, and the decor for the children's day rooms.

HEALTH SERVICES FOR CHILDREN IN GREAT BRITAIN

In 1948, local authorities (government) were given responsibility for health visiting. Today, the health aspect of the child's care is under Health Services while the supervision of day care, nursery schools, home help services (homemakers or daily "minders" for hire) are under social services.

Home health services provide booklets on child rearing for easy, inexpensive purchase or for free distribution as well as the services of a health visitor who teaches face to face as well as in more formal settings.

The home (or district) nurse is an RN with hospital training plus additional training in the social and emotional aspects of care. She has had a four-month in-service training in home care to adapt her hospital experience to the home. The health visitor is an RN with obstetrical or midwifery training plus an additional year of public health nursing. Her job is purely preventive medicine.

"Our main aim is to keep children out of hospital because of the potential emotional disturbance to them there. We feel that the child should not be admitted unless it is for skilled nursing and skilled medical care that he cannot get in the community," according to Miss Earl, the Public Health Nursing advisor for the Health Services, Children's Division.

STUDY DAYS

Staff members are granted several regular "study days" with pay each year to attend conferences and sessions dealing with subjects related to the well-being of children and their families. A number of volunteer agencies participate with representatives of the Ministry in presenting such conferences.

These study days are planned to offer common experiences to all participants and to provide opportunities for representatives of different disciplines to come together around topics that concern the well-being of the child patient. Course content includes items such as the emotional and developmental needs of children; organization to meet these needs; problems of special groups of children; the role of the parent in the ward, whether visiting or living-in; the relationships between staff members and family members and relationships among the ward team of doctors, nurses, play leader, volunteers, etc.

I attended one such study day sponsored by the Play In Hospital Liaison Committee at the King's Fund Hospital Centre* on the subject of "The Role of the Hospital Play Leader." Fifty-eight participants included nursery nurses,

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* The Centre, an independent charitable organization founded in 1897 as a

occupational therapists, play staff members, both paid and volunteer, research assistants, representatives from Save the Children, NAWCH, nursery school teachers, psychiatrists, pediatricians and nurses.

Attitudes Toward PARENTS and Play

In the course of the conference there was a discussion of the spotty implementation of play programs and of living-in programs for parents. Some nurses expressed annoyance at being pushed into a villain role as other groups move into the hospital and take over pleasanter aspects of care. Some nurses resent having parents and play leaders step in to offer consolation and pleasure to the child after the nurse has given an injection. Play leaders and parents were urged to share the "good guy" role by slipping a sweet for the nurse to give or coaching her to pick the child up to offer comfort following an unpleasant procedure rather than pushing the nurse aside and administering the sweet and comfort themselves.

In hospitals where nursing staff, play staff, volunteers, and parents all participate in care, competition for the child's time can be a problem. All see themselves as important to the child's well-being. Sometimes nursery nurses and play staff members disagree about who has responsibility for the child's recreation. Consequently, especially where play space is located some distance from the ward, the play program is less well-used than it might be.

Participants at the conference agreed that for play programs to be effective, support from the top is needed. The more authoritative (authoritative here correlated with frequency and familiarity on the unit) the person who touts play, the more play programs are integrated and supported. The fact that not all hospitals yet accept play as an important activity in pediatrics was evidenced by one nurse who rose to say, "We don't need a play program in our hospital because our children are too sick. When they are well enough to play, they are well enough to go home."

Another concern arose: the time structure and identity of the play leader, how she might elicit maximum cooperation and harmony with representatives of other disciplines within the hospital. For example, should she help by doing nursing tasks? By changing diapers? Should she go on rounds? Was she responsible for the operation of out-patient department playrooms? Was

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* cont.
memorial to Queen Victoria's Diamond Jubilee, possesses substantial capital resources, the income from which is used solely for the benefit of hospital and health services. The Centre's chief aims are to provide a forum for the discussion of current problems and to help accelerate the introduction of good ideas and practices in the planning and management of health services. The Centre has four main functions: conferences and meetings; exhibitions; library and information services, and research and development. Its facilities are available to anybody concerned with health services at home or abroad.

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the play leader the logical person to accompany children to the operating room? How much time should the play staff spend with children in isolation? What, in other words, was the best use of her or his time? A Major concern was that the play leader not assume the whole burden of preparing children for major surgery. The group agreed that such preparations should be by teams.

Mothers made their plea, too. "Please tell us what to do. Free play is fine for children, but we mothers need more structure." Another recurrent theme of the conference was the importance of communication. One volunteer play leader wanted more information on the significance of the child's diagnosis. "I always feel uncertain about how to handle the children because I know so little about their medical problems or how to care for them. I'm constantly uneasy about whether or not to carry them or whether they should be allowed to engage in certain activities."

Representatives of several hospitals described their preparation programs. At Charing Cross, preparation for surgery is done by play leaders in the presence of the parent with the cooperation of the operating room team and the ward staff. The play leaders use books such as *Paul Goes to the Hospital*, developed at Charing Cross for older children. For younger children they use *Zozo goes to Hospital*, by H. L. Rey, and the child plays out the story with a Zozo monkey puppet. They also offer children a "hospital box" of props for playing out experiences.

At Brook Hospital, a tonsillectomy play preparation program takes place each Monday. At this time, one nurse is assigned to follow the group throughout their hospital stay. She brings a hospital box with props, dresses up in the garb of the operating room, offers the children rides on the gurney, and handles all the nursing care. She accompanies her patients to the operating room and is with them when they wake in the recovery room. Her voice, having become familiar in the course of previous play and caretaking, reassures the children when they hear it again in the recovery room.

VOLUNTEER AND CONSUMER GROUPS

In addition to Ministry of Health, several volunteer organizations work to help hospitals and families recognize the needs of children in hospitals. One such organization is the National Association for the Welfare of Children in the Hospital (NAWCH), with four thousand volunteer members who operate out of an office in London with a paid staff of one person full-time and one half-time. There are sixty-five constituent groups throughout the United Kingdom and a few members in Denmark, Holland, and South Africa. Two chapters have been organized in the United States. NAWCH was organized following the release of the first films by James Robertson describing the plight of children without parents or play in hospitals. The group's goal has been to encourage and assist hospitals in adopting the recommendations of the Platt Report and to educate families and communities to seek out those programs that offer appropriate, child-centered care. NAWCH keeps information about children and hospitals in the public eye by placing posters in public places, by distributing to hospitals and families literature about good ways of supporting young children during hospitalization and has developed slide and taped scripts about children's trips to the hospital to be used by nursery schools.

As not all hospitals conform to the recommendations of the Platt report, NAWCH helps parents find out which hospitals offer parent beds by keeping a record of the policy of each hospital and the number of parent accommodations. NAWCH conducts play programs for hospitals with volunteers who have taken special courses to prepare them as play leaders. The goal of the volunteer work is to demonstrate to hospital administrators and staff members the value of play so that the NAWCH-led program can be replaced with a professional staff supported by the administration. In England, salaries are low and standards are high, resulting in fewer play leaders and play programs than are desired.

NAWCH groups also provide transport services to enable mothers to visit sick children; organize child-minder and play-group services for other children; raise funds for mother and baby units, and provide material and equipment for the under-fives in hospitals while maintaining friendly contacts with local hospitals.

Save the Children Fund

Another organization contributing to the welfare of the hospitalized child is the Save the Children Fund (S.C.F.). Save the Children is an independent voluntary organization, professionally staffed and now more than fifty years old. Its purpose is "the rescue in disaster and the longer term welfare of needy children, irrespective of nationality, race or religion." SCF helps children in nearly fifty countries with teams of over 1,000 field workers including doctors, nurses, welfare workers, and administrators. Its goals are to create conditions in which children can grow to a healthy maturity and, overseas, to train local workers, where necessary, in the professional and technical skills required for child welfare. Over the years, SCF has raised and spent nearly thirty million pounds.

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Save the Children Fund prepares play leaders and will, for a brief period, pay salaries for them in a hospital while programs are beginning. This Save the Children subsidy is supposed to be replaced by the hospital's administration once the program has proven its worth.

Save the Children also finances exchanges of play leaders between different countries. They will help with placement in a play program and with housing for two months and offer consultation to the exchange person. Play leaders must pay their own fare, but housing and placement assistance is provided for the two month visit. *

Funding

Save the Children Fund's contribution, as of 1972, has been approximately ten thousand pounds per year for the sixteen hospital playgroups it established. A Christmas appeal netted funds for the establishment of play schemes in two hospitals. Students of Aston University in Birmingham raised money to finance a hospital playgroup in their locality for at least two years.

NAWCH, too, raises funds and finances hospital playgroups. Indirectly, their educational efforts for the community attract financial help from other individuals and agencies.

Toy Library

Toy library materials for mentally retarded children were displayed at the study day conference along with descriptions of the Noah's Ark Toy Library program, a service organized and operated entirely by volunteers throughout the United Kingdom to raise funds and buy sturdy toys suitable for children with handicaps. Local organizations tour the countryside placing the toys with families and offering consultation on their use.

This helps families avoid the possibility of an expensive mistake in toy purchase. Toys can keep up with the child's development. The representative of the Toy Library can do tactful guidance to parents in choosing and presenting toys. The toy librarians also make a variety of toys to meet special needs. A texture lotto game is an example.

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* Interested persons may contact Susan Harvey, Save the Children Fund, 29 Queen Anne's Gate, London S.W., England

Role of Volunteers

Volunteers play an important role in England in helping to humanize hospital care in pediatrics, especially where play is concerned. As money is scarce, their services are needed and encouragement and assistance comes from the Hospital Play Liaison Committee, the Friends of Hospital and, of course, NAWCH and Save the Children. Every local authority runs courses for adults on how to run play groups. The above organizations supplement this knowledge with additional information about hospitalized children.

The following suggestions came from the conference sponsored by the Hospital Liaison Committee for volunteers and play leaders:

Play leaders need to know how to deal with children's emotions intelligently, and how to deal with deprived children and how to cope with deprivation.

They must understand the meanings of tests and have enough knowledge about medical procedures that they can supervise children safely and adapt activities to the children's particular disability.

Good communication among play staff, medical staff, and parents is essential.

Play leaders must be professional in maintaining confidentiality, sharing relevant material with the health care team, yet never gossiping.

They must help staff understand play functions.

Play leader's time should not go for rounds; instead they should build enough rapport and trust to enable them to exchange necessary information about their children in a more condensed form.

Adequate training for volunteers adds to their status and to the entire play program. Their training should include, 1) Knowledge of normal growth and development; 2) Experience with well, normal children; 3) training and experience with hospitalized children.

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INTERVIEWS WITH JAMES AND JOYCE ROBERTSON

The Robertsons have been working on behalf of young children for many, many years. In the early 1950's Mr. Robertson made his first filmed account to show first medical professionals and then the general public what hospitals were doing to their very young patients. When no results were forthcoming insofar as modifying hospital practice, he took the film to television and asked for viewer response. The results of this response led to the publication of a number of case studies as well as to the formation of NAWCH. Eventually, the Ministry of Health took heed and their concern led to the adoption of the Platt report.

The Robertson's work is truly inspiring. Not only has it changed the hospital climate to a large degree in England, but that influence is spreading world-wide.

I counted myself fortunate indeed to have Mr. Robertson's guidance prior to my visit in pointing out programs to visit, and the privilege of chatting with the Robertsons at home was a high point of my trip.

The Robertsons are concerned about too early separation for the child, whether in hospital or in too early day care. Their films on Brief Separation point out the damage incurred by a young child when no single caretaker occupies a central place (or the child occupies no central place in the caretaker's scheme). It is their belief that a series of kindly but changing strangers, no matter how well-trained or well-meaning do not substitute for a central, stable parent or parent equivalent. Mr. Robertson points out that historically mothers bring their children to the centers at first quite nervous about leaving them and call frequently to check on their well-being. After several weeks, they drop this behavior and soon begin to complain that the center doesn't offer more services ... such as providing the child's main meal. Often the staff at the centers construe this behavior to mean that the parent is trusting them now, but the Robertsons view it as gradual erosion of natural parenting behavior so essential to the child's healthy development.

In one of my own later observations at a day care center I was told by the director that although each four children have a special grown-up to relate to, they soon outgrow this dependence and after a few weeks only seek her out when they need special comforting. As the center was on the same premises as the parents' job, I asked if parents ever dropped in to visit. "No. The parents' lunch and the children's naptime coincide."

The damage is silent; the bond is never missed because it never develops, but what is not developed through that missing bond is the child's desire to please and to mind; to mark individual styles; to focus and concentrate...essential to learning; to feel intensely; to love. The lack of early bonding results in later indifference to learning; inability to concentrate; shallow relationships; divorce; disinterest in parenting one's own children, and irresponsibility.

Nursery schools are prevalent and important in England, and the Robertsons are much in favor of them when they do not usurp the parents' role for long periods of time during the first three years.

What is the parent to do who must work to survive financially or to keep self-esteem and intellectual life alive? Perhaps a society might find ways of meeting these natural needs with something other than full-time separations between mothers and their babies.

He suggests that perhaps sick leave might be paid to parents of ill children, either in or out of hospital, in recognition of their interdependence during those early years. So far, quite the opposite is true: nurses report that increasingly they have to admit children formerly cared for at home with childhood infectious diseases requiring isolation because parents cannot take time off without penalty.

Mr. Robertson hopes that the efforts of NAWCH as well as education through parent centers, nursery schools and the formal educational system will eventually make parent living-in common practice when children must go to the hospital. Word of mouth is the most effective way of educating the country about children's needs.

His further concern is that too often people are not allowed to do what they are educated and trained to do ... nursery nurses, parents, and all have so many divergent tasks piled on top of their primary roles.

"We need somebody with major responsibility to manage the wards. This person should have preparation in child development. We must change the conception from a hospital model to a home model, spare the child constant change of staff." Mr. Robertson would put the child under the wing of a principal or caretaker, bringing in medical or nursing staff as consultants. Children could use the time between treatments to continue their lives normally. As hospitals gain a reputation for truly wanting parents around, word spreads, but "when the physician feels omniscient enough to choose which parent can stay and which cannot, parents are less inclined to ask to stay."

HOSPITAL VISITS

The hospitals visited in England included Great Ormond Street Hospital for Sick Children, Fulham (Charing Cross), Amersham, Stokes Mandeville, St. Mary's Praed Street Mobile Unit.

Great Ormond Street

Great Ormond is a group of large old and newer buildings surrounding a courtyard. On the building that houses pediatrics, some of the balconies overhanging the courtyard have been enclosed to form parent alcoves in children's rooms.

Here I first observed that nurses in England dress to suit their rank. Clothing varies from the high-necked grey uniform of the Matron Sister with a small filmy cap perched on her head down through several gradations, quite distinguishable to the British professional. Colored uniforms -- still an issue in this country, have always been worn in England, but there each color denotes status. There are Super Sisters, Matron Sisters, Sisters, Nursery Nurses and students, each in her own specific costume. Although professional postures are erect and formal, and the buildings themselves austere, there is something cozy in the air. Beatrix Potter characters, and Pooh, Piglet, Kanga, and Christopher Robin adorn halls and walls. Children not in isolation are grouped together; inside the rooms babies are held by mothers (always referred to as "Mums") nurses, or nursery nurses.

Great Ormond Street first opened its doors in 1862 with 10 beds for children. Today it is a teaching hospital with 340 beds admitting 9,000 children each year. There are 6 medical units of 20 beds each, 4 parent beds plus an additional 2 parent spaces in isolation rooms for each unit. The father of one patient recently contributed funds to provide additional parent rooms and services as well as for the decoration of the nurses' sitting room-office.

There are several pediatric floors with children grouped according to age. The mothers' sitting room and kitchen for the hospital adjoin the infants' nursery, because the majority of mothers who stay are breast feeding. One play suite on a lower floor of the hospital serves all the wards and is presided over by a play leader and her assistant. The wards themselves are also equipped with playthings for mothers and nursery nurses to use on the wards. Children's wards have beds surrounding a center clearing where round tables and chairs are grouped for eating and play.

Great Ormond Street's brochure states: "There is a special residential accommodation at the hospital for mothers who are breast feeding their babies. Accommodation for other parents who need to stay with their child is very limited, but the medical social worker can give information on hotel accommodations nearby." However, at least one floor at Great Ormond Street conforms to the Platt Report's suggestion of four parent beds to every twenty patient beds. Parents who ask to stay are given free room and board as long as space is available, but these facilities are not

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advertised. Parents who stay eat at no cost in the nurses' dining room. Nurses must pay for their meals, so this is a sore point with some.

Amersham General Hospital

James Robertson suggested the visit to Amersham General Hospital in Bucks County as one with a parent program in full swing. This program was inaugurated by Dr. Dermod MacCarthy and the then Matron Sister twenty years ago. Dr. MacCarthy was one of the first physicians who, though at first doubtful of Robertson's message, came to subscribe to it wholeheartedly. Amersham welcomes "mums," and has open visiting for siblings, grandparents, dads, and all significant others.

Amersham is a small country hospital located in gentle rolling green countryside opposite an ancient stone church. The town of Amersham dates back to William the Conqueror. The hospital is a series of old flintstone buildings with two modern concrete and glass structures and a few modules more recently added to house the rehabilitation unit, the nurses' residence apartments, and the creche (day care center) for staff. The pediatric unit is a long, low ground-floor wing on one side of a quadrangle. Outside the ward itself is a small square office used as a nursing station, for staff meetings, for record keeping, and for reports. Off the corridor connecting this office to the ward are the parent kitchen and sitting room. The ward itself is a large, windowed area with beds on three sides with parent chairs, toys, and chests for children's personal possessions prominently displayed. Adjoining the ward is a play porch with a T.V., some comfortable upholstered rocking chairs, and a welter of toys and furniture very homey in character. Children and parents wander freely. Meals are served family style and eaten where the diners prefer -- in bed, at the center tables or, in the case of parents, in the parents' lounge.

Matron Sister Daniel, nursing supervisor for pediatrics, scoffs at the idea of disallowing parent visiting before surgery. Mothers stay with children and hold their hands as they go under the anaesthetic in the operating room. "Of course they sometimes hate the blood and the smell, but they're mums ..... that's their responsibility," Miss Daniel says. How word of parent accommodations gets out? "After twenty years, it's just general knowledge." Parent education? "Only surreptitiously."

"We are a dying breed -- the spinsters married to our work. I don't know who will replace us," said Matron Sister Daniel, who practised nursing as a missionary in Africa until illness forced her to return to England. Having seen how well African children managed medical treatments including hospitalization when parents stayed with them, she vowed on her return to hospital nursing in England that never again if she could help it would she hear that heartbroken crying of the lonely abandoned child. She felt at home at Amersham with its mothering-in policies. She trusts parents.

At Amersham, one consultant pediatrician and various subordinates are committed to policies of unrestricted visiting and to the accommodation of

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mothers with infants from birth to five years (and older if necessary). Parent-child cubicles line the outer wall of the large wards. Each has one door to the ward and one to the outside to provide exposure to circulating air and reduce the danger of cross-infection. Many children whose parents live in are in isolation. Glass walls to the cubicles allow two-way observation. Mothers may draw shades for privacy. Each unit contains a parent bed, a crib for the child, a rocker, and a wash basin. As at Great Ormond, an additional parent living room and kitchen are provided. Parents serve themselves from food carts on which meals are brought in for family style serving.* They eat with their children or, if they prefer, retire to the parents' unit. If there are not enough beds for parents in or near the children's ward, parents are housed in the nearby nurses' residence hall, a modern, well-appointed high rise on the hospital grounds. No request for over-night accommodations by a family member has been turned down. Parents, eating and chatting together, usually form a strong social group, listening sympathetically to each other, minding each other's children when one must return home to check on the family there, and encouraging each other in their day-to-day encounters with staff members and patients.

When there are few physicians and many parents, the doctors sometimes feel the need to duck the questions so many parents have at the ready. Dr. Garrow admitted to a tendency to come through the bushes around the outside of the building, timing his rounds for just after dusk in order to conserve time and elude some of the more persistent questioners.

One mother, interviewed in her cubicle at Amersham, said she had received no advance information either from the hospital or from the health visitor about living in. "I heard somewhere ... maybe from the nursery school ... that it's good to stay when they are little like this." She had been delighted to learn that she could stay at no cost for bed or meals, but she had not been prepared. Fortunately, after the Sister informed her and her husband that a bed was available, her husband had found last minute help to care for their child at home, rushed home and brought back a suitcase for the mother.

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* Supper the night I stayed was spaghetti with poached egg, mashed potatoes, white bread and cobbler.

Stoke Mandeville

Twenty miles from Amersham in Aylesbury, Bucks, is Stoke Mandeville Hospital. The pediatric unit, much larger than its counterpart at Amersham, is one section of a very large hospital that specializes in the treatment of paraplegics. The buildings are arranged so that specialties are housed in long units resembling wartime barracks extending at regularly spaced right angles to the corridors linking them. Again, the pediatric unit is on a ground floor, and some of the children are able to play outside occasionally as evidenced by a play yard with climbers and slides.

Although the atmosphere is institutional with long, unlovely corridors, bewilderingly complex networks of doors and anterooms, children appear relaxed and comfortable as they wander around or sit with their families, including brothers and sisters, most of whom are present. Parent-child cubicles line the outer walls of the unit. A small cozy chintz-decorated parents' room was full of chatting mothers, sharing stories and listening attentively to each other. Even in their small quarters, an additional parent cot had been fastened to the wall to be pulled down for extra sleeping space.

The consultant pediatrician is Dr. Dermod MacCarthy, physician seen in *GOING TO THE HOSPITAL WITH MOTHER*. Stoke Mandeville and Amersham work in unison. Both consultants are, in Mr. Robertson's words, human and enthusiastic.

At Stoke Mandeville the matron-sister conducts daily parent rounds. She solicits questions; tells family members about treatments planned and about the doctors' comments on the child's care and treatment; and suggests how parents can help during the day.

Matron-Sister Gilbert described her conversion to parent-inclusion by saying: "Nobody could have convinced me that it was a good idea to have parents around; Dr. MacCarthy ordered me to bring parents in. I hated the idea. Only watching the parents and the children showed me that children do indeed do better with their parents here, and that parents are not as difficult as I had feared; they are, for the most part, a help. I am afraid that it is my sisters, the nurses, who object to having parents in the hospital and the only way to change their attitude is to bring them to visit wards that have parents and let them see for themselves that parents help."

Mimeographed guidelines are distributed to mothers living in the children's ward. The paper includes instructions about food and drink, crib safety, obtaining information, and going home. Some excerpts suggest the flavor of Stoke Mandeville's program:

> Visiting: "Your cubicle is, in a sense, an outpost of your home in which medical or surgical things can be done. Your husband or a friend or one of your children (providing Sister is asked) can come and visit you at any time."

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Behavior of Children in Hospital: "Some children cry noisily and make a great fuss when a doctor or nurse comes to examine them or do something. This is normal behavior, we are quite accustomed to it. It is probably better for a child to protest and cry for Mummy than to be examined by strange people or undergo injections etc. alone without anybody to cry to, so please don't think we shall think your child is behaving badly."

Playing with or doing things for other children: "We want you to do the simple nursing, washing, occupying etc. of your own child, but not undertake these things for any other child. However, we do like the mothers to come out and join in the life of the ward and there are certainly lots of ways of helping other children who have not got their mothers or visitors; especially the little ones. We welcome your help here."

Going out or going home: "Please don't think you must remain beside your child the whole time. You are free to go out or go home for a short time if you can, provided you tell the Sister or Staff Nurse. Your husband can sometimes relieve you."

During visits to Amersham and Stoke Mandeville, an impressive number of parent-to-parent encounters were observed in patient rooms and parent lounges. No signs admonished parents to housekeep and clean up the premises, but nevertheless, they seemed to pitch in and tidy up as the situation demanded it.

At Stoke Mandeville, Matron Sister Gilbert mentioned an occasional problem with mothers feeling obligated to come. One mother laughed when asked about this, saying: "Did you ever try to tell Dr. MacCarthy you didn't want to stay with your child?" Customarily, during the parent's interview with the physician, when hospitalization is discussed, the doctor says something to the effect of "You are staying, of course, aren't you?" and some families do feel obligated as a result. Social service can recommend home-care givers, but most families manage home care with the help of relatives, neighbors, or nursery school confreres. Often parents bring other children with them. A NAWCH volunteer who operated a daily play program for both patients and well siblings had recently moved, leaving the hospital with no program. "It is hard for them (the parents) to be solicitious of the patient whilst trying to keep an eye on several other active little ones, but they manage," Matron Sister said.

Parents who wish to may cook their children's favorite foods at home and bring them to the hospital to tempt appetites. A growing East Indian population makes this especially important for the many children to whom English food is foreign.

Play at Amersham and Stoke Mandeville takes place directly on the wards and in the cubicles, spilling over at Amersham onto a cozy play porch awash with toys, rocking chairs, and television. Children and parents appear comfortable and at ease. Children of mixed ages grouped together

help each other. One eleven year old girl, seen during the Amersham visit, spent a lot of time feeding, stroking, and crooning to a severely retarded deaf-blind baby on the unit. Parents, too, interacted with each other's children, giving the wards a village-like ambience.

Neither Amersham nor Stoke Mandeville had a play leader at the time of this tour, although both Nurse Matrons expressed a desire for more structured and supervised play programs. Both hospitals had previously had programs and missed them. Meanwhile, parents stay and are encouraged to bring toys. Because families, including well siblings, are around, the children appear occupied and involved.

St. Mary's, Praed Street

St. Mary's is in Paddington, a poor section of London. It is a giant red brick 19th century edifice directly across from a University medical school. The visit here centered on a mobile hospital unit manned by a pediatrician and a nurse. This unit, the only such in London, is designed to bring the hospital into the home. Recently improved housing conditions and improvements in the general health of the child population have reduced problems that call for hospital care.*

The mobile unit itself is a large van donated to St. Mary's by the Variety Club, but it usually remains parked outside the hospital because the team prefers to use the sister's car. The van is unnecessarily large and harder to maneuver, and some families object to having it parked outside their homes. "The best thing about the van is that it doesn't collect parking tickets," the nurse said.

Calls are made to families living in a wide variety of housing situations throughout the Paddington section of London. On the day of the visit the team's itinerary included calls on a frightened West Indian toddler with an infected ear, several young children in crowded flats who submitted to examination cooperatively on their respective mother's laps, a tiny little Vietnamese two-year old with tuberculosis whose family lived on the top floor of an elegant embassy building, and an asthmatic East Indian ten-year old whose mother spoke no English. The team came to see him because their help allowed him to attend school fairly regularly despite his frequent severe attacks of asthma. While the physician and nurse were at the boy's home ... a brand new housing unit where he lived with his mother ... they did postural drainage and showed his mother how she could help him in the same way. The boy translated their instructions to his mother.

It was impressive how rich the visits were in peripheral instruction to families and to neighbors, as well as the children themselves. At one stop, the doctor chatted and questioned the father while the nurse fetched

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* An increase in working mothers, however, is causing a resurgence of hospitalizations for contagious diseases once managed by families at home.

the little girl home from recess at school. She was back in the play yard before the period ended. Her father and she proudly displayed the birthday card the nurse had sent her the previous week, and the mutual fondness existing between the nurse and the families was obvious.

The mobile unit has been in use for 18 years. The home nurse who serves as part of the mobile unit team is Sick-Nurse trained. Her training differs from the Health Visitor's in that the Home Nurse extends the hospital into the home, treating the ill child.

Dr. Thomas Oppé, Chief of Pediatrics at St. Mary's, described the Mobile Unit and its services:

The mobile unit dramatizes the idea of keeping the young child at home. It is not for emergency care, neither an ambulance nor a flying squad but more than a house call by the doctor. (Doctors in Great Britain still make home visits.) Great Britain still uses more general practitioners and fewer pediatricians. To some extent the mobile unit serves the general practitioner by sending Pediatricians into the field to give their in-put and consult to the General Practitioner. The Home Nurse reports to the Home Visitor regularly assigned to the family's case while the Pediatrician reports to the General Practitioner.

In addition to its service to the family and the regular health care team that follows that family, the mobile unit is useful for the education of medical students and physicians.

The unit keeps children out of the hospital offering both economic and emotional advantages.

Although not all patients on home care would necessarily be hospitalized, not all children in hospital really need to be there. Caring for the child at home is better for parents in many cases because parents in hospital are fish out of water. When they are not instructed as to how to help, they tend to just sit. This is less helpful to the child than some people believe, Dr. Oppé thinks.

Home care, on the other hand, builds up the confidence of the mother so that she does not always rush her child to the hospital. Home care is often indicated for children who have seizures, asthma, or for dying children. The home care doctors and nurse need to be very sensitive, skilled and confident. They face hard, fast decisions and these must be made in close contact with parents. Not just any nurse or doctor can manage the task. They cannot have too restricted a view of nursing or medical functioning. They must be friends of the family.

A mother cannot initiate her home care. Referrals must go out from the General Practitioner. After the home care unit has the case, then the mother may alert the team if she feels there is need.

The home care team has no executive function. They do not make referrals to social workers, for instance, but report directly to the Family Practitioner and the regular health crew takes over from there.

Fulham Hospital (Charing Cross)

At Fulham the pediatric in-patient unit is on the ground floor, a happy arrangement allowing children access to outdoor play yards and offering views of greenery and activity. The wards house about thirty children, twenty for middle-aged children and smaller rooms for infants and toddlers occupying the same suite. Adjoining the bed units several play porches offer sand, water, carpentry and clay projects. Many children were up, sitting at the center tables or playing in the anterooms. Parents sat on straight chairs by their children. Parent quarters or accommodations were not in evidence. Children's art decorated the walls. Many windows gave the rooms a bright, cheerful, lively aspect.

Fulham's well-staffed, active play program is financed by Save the Children Fund. The three play leaders move among the children, parents, and staff ready to help with crafts, to interact with toddlers, or to prepare children for treatments using the battered box of doctor play equipment. The ward is colorful with children's paintings and buzzing with activity.

My visit found a boisterous group of boys playing in the sand pit while another group built airplanes at the carpentry bench under the watchful eye of two young men trained and placed by Save the Children Fund. In shed-like structures adjoining the large ward, a group worked with clay in an art room equipped with materials for all kinds of creative projects.

The ward itself had beds arranged so as to leave the center free for small round tables and chairs, wheel toys, and various play projects for younger children.

At one end, an Indian boy, about 12, was coming to following surgery. His family and the father of the child in the next bed, restrained him while the nurse administered a shot.

Two beds down, a couple of five-year olds played house on their beds surrounded by a portable Wendy House made of covered folding screen. They served each other pretend tea in doll cups, resting after hanging out their doll laundry on clothesline strung between their beds.

Across from them, an Indian boy in traction watched shyly, taking an occasional swing at a punching ball suspended within his range from the bar over his bed.

In the center, at a table, an eight-year old missing his left arm played a board game with two student nurses. They interrupted the play to take vital signs, then calmly resumed the game.

The leaders strolled from bed to bed, offering and joining play. A two-year old bustled along behind, bearing the suitcase with the doctor play materials -- a teddy bear, some bandaids, a stethoscope, some syringes, and a mask or two. These are some of the materials the play leaders use to prepare children for procedures they may soon encounter.

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THE NURSERY NURSE

In England, girls just beyond high school age may take a two year course that prepares them for positions as nursery nurses. Their training parallels that once offered to prepare "Nannies" who cared for the children of wealthy English families. Today, while part of their training may include placement with an individual family, they are offered a program that allows them to choose positions in hospital pediatric units or in nursery schools. The preparation includes child development and health care. Both of these serve also as pre-parenthood education and it is the expressed hope of program advisors in the Ministry of Health and among the leaders in the volunteer agencies such as NAWCH and SCF that young women so educated will be more aware of their own babies' needs for support and attachment when they,too,are mothers.

Part of the training includes recognition of the young child's play needs and education on the delivery of age-appropriate play to the children.

The profession of Nursery Nursing has its counterpart in Denmark (caretaker nurse) and Sweden where the position is called Child Nurse. The Nursery Nurse or Child Nurse is different from the Play Nurse who is responsible solely for play. The Nursery Nurse delivers mothering care that includes diaper changing, temperature taking, feeding, and bathing along with play.

Both the Child Nurse and the Nursery Nurse positions are first steps on a career ladder. Certified at the end of their two year course, the graduates of these programs can stay in that position or can later decide to take course work preparing for more advanced degrees and status in either nursery school education or in nursing.

Nursery Nurse preparation involves three different sets of in-hospital behaviors: one-third are prepared to serve on maternity units in the care of the new-born. In-service courses teach them cross-infection prevention techniques, tube feeding etc. They work as aides to mid-wives. "Pediatricians are greedy to get hold of them because they do better with failure-to-thrives than do nurses or mid-wives," according to the Nursery Nurse government advisor.

A second third have preparation in sick children's units in the hospital.*

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* At the time of the visits, a work party was studying hospital units to determine the play and companionship needs of the children on the unit in the light of proliferating services to meet mothering and play needs of hospitalized children. Sometimes competition over the child arises when several groups of interested caretakers, including parents and volunteers, all wish to meet the same needs. Sometimes the child is missed by all, falling through the cracks.

One-third get training for work in day care and nursery schools. Nursery Nurses also staff hospital day care nurseries.*

Candidates for training as Nursery Nurses must be at least sixteen. Students over the age of eighteen may have their course of study shortened from two years to eighteen months. Their training takes place in the particular establishment where they are placed with children younger than seven years. The training period is planned to ensure continuity both in the training of the student and in the care of the children.

Every candidate must submit to her training authority a factual and spontaneous record of observations of children made throughout her course. The significance of the observations is discussed by the student with members of staff both in the nursery where she is placed and at the training center. Students live and help with the children. They have opportunities, for a substantial period of time, to see how children behave and how they change. This understanding of growth and development is the basis of the training. Students are expected to supplement their observation of young children through informal contacts with those they know in their own homes.

Each training establishment has devised its own curriculum and keeps records of each student's practical experience. The government offers a framework to guide those responsible for the course. This includes the following suggestions:

A. Students are expected to learn what young children are like at different stages in their growth and how they should be cared for. Students gain their knowledge through practical and theoretical training and through suggested reading.

B. Some children with whom the students work will have a family background, others will be cared for away from their families. The importance of various aspects of the children's circumstances should be considered.

C. Those responsible for the children must consider the means whereby the children's physical, intellectual, emotional and spiritual needs are met. In addition, students must know about such everyday matters as food, shelter, clothing, and other physical provisions. Children need opportunities for play and language development, for companionship and the sharing of interests and activities.

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* The ministry has not encouraged day care for nurses because, they say, "If you are a good caring person, as you should be if you are a nurse, you should care for your own before you care for others." A brochure has been prepared for distribution to hospitals asking them to look at the need and the cost in relation to the long term reward and danger.

D. Students should also realize the importance of continuity of individual care for the child, the need for responsible, confident relationships among adults and with children, and they should have an awareness of spiritual values. A detailed study of the means by which these basic needs of children are met, from babyhood onwards, is therefore necessary.

E. Throughout training, as students observe growth and development, they need particular help to understand the interdependence between the physical, intellectual, and social-emotional progress of babies and young children. Most of their experience will be with normal healthy children, but variations in development will be discussed.

F. Knowledge of health matters such as good nutrition; prevention and control of infection, both day to day and during outbreaks of infection; the prevention of accidents; elementary first aid; and simple steps to be taken when children are ill or convalescent, are taught. Experiences with care of children individually and in groups are taught and compared.

G. Students are expected to assume increased responsibility throughout their two-year training, although still working under the guidance of experienced staff members. Students are advised to remember that they should see themselves as one of a group caring for children and follow the pattern of life in whatever establishment they are placed. Advanced students are expected to contribute to the training of other students and young assistants.

H. Students take other course work and are expected to maintain a lively interest in life, taking every opportunity to enrich their own interests. Students younger than eighteen are required to take additional course work arranged under the general topics of:

I. English and the Creative Arts
II. Man and His Environment
III. Home and Society

I. Every candidate must produce evidence that she will complete a course of study designed to increase her knowledge in vocational subjects and to her own personal knowledge. In addition to study of the care and development of children, her studies should also cover household arts and management and the study of certain aspects of social conditions.

J. The Department of Education and Science is responsible for approving all establishments seeking to serve as centers for practical training of nursery students.

K. Some students spend the entire two-year training period in an establishment catering to a wide age range of children; others divide the training between two establishments with not less than a year in each. It is expected that the choice of two complementary establishments gives the student experience with children in either day or residential nurseries or nursery schools and either nursery classes or infant schools.

L. It is expected that each training establishment devise its own curriculum and that records of a student's practical experience be kept.

"Children need the companionship of lively minds and it is hoped that the student will take every opportunity to enrich her own interests. She should be encouraged to expand her own understanding through reading and through the development of her own creative abilities. A course of general studies enabling her to do this could be devised in such a way that consideration of the nature of man, the value of life, the wonders of nature, and the place of the arts and sciences in human life and progress could all be presented to help towards both a personal enjoyment of living and a philosophy of life."

The three headings as listed for additional course work are expanded to include the following:

I. English and Creative Arts:

Aimed at extending the students' powers to use their own language and enjoy its literature, and to find ways of self expression through music, art and drama. To achieve this it is necessary to create an environment in which the student is stimulated to use her natural abilities rather than to impose a discipline of work.

II. Man and His Environment:

The nature of the physical world and the use and misuse of man's mastery over his environment is constantly before us. To understand this it is necessary to have some knowledge of the laws of nature and man's place in the cosmos, together with an appreciation of living things and their interdependence.

III. Home and Society:

The aim is to obtain factual knowledge of how society has developed, is organized and sustained: to find how to enjoy its benefits and serve its needs; to examine the rights and responsibilities of the individual in relation to the home as the basic unit of society.

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Schemes of work are not provided, so that teachers are free to develop the subjects under the three headings in a way most appropriate to their students.

In the changing pattern of adolescent development, in the need for relevance to their situation, the teaching should break away from traditional divisions of the timetable and the conventional treatment of subjects.

The paper goes on to suggest that modern techniques of visual aids be employed and that "people of lively minds and varied experience be invited to visit and contribute to the course" ..... outside excursions are also suggested.

In light of the above, Mr. Robertson's comment was: "Our task now is to see that Nursery Nurses have the opportunity to practice what they are taught in the institutions where they later pursue their careers."

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DENMARK

PREVENTIVE HEALTH POLICY

In the 1950's, 56% of all deliveries were at home. Mid-wives visited prior to the birth of a baby and then notified the health visitor for follow-up care. At that time every birth was followed by a health visitor. Today, most babies are born in the hospital and home visiting is selective and limited to homes where there is a problem. The first home visiting included every home and was for one year, later expanded to three years. Today's emphasis is a compromise between the original blanket visiting and the policies of selective visiting following early assessment that are planned for the future.

One reason that selectivity is important is that only 700 health visitors, 500 of whom are full time, are available. Denmark needs 800 to meet all the health needs including school health at a ratio of 6,000 population to one health visitor. At present the government has neither the funds nor the qualified applicants to fill all the slots. The birthrate is rising at a rate of 17 per 1,000, and is currently at 80-90 births to each 6,000 population.

A move to form teams to help with preventive health is growing and local authorities encourage this by providing space to such groups. Teams would be composed of a public health nurse, a physician and a health visitor. Some resistance to the inclusion of the health visitor comes from the physicians for fear that sharing practice with them may be a step toward socialized medicine.

Public health nurses work out of their homes on a basis of three days of home visits and two days of school nursing. The district nurse visits in the community selectively as requested by the private practitioner or the hospital. The chief of the hospital department of pediatrics serves as consultant.

There are 2200 home nurses, all RNs without the post-basic preparation that the health visitors have. Demand for them is declining either because health is improving, mothers are becoming more competent or because children are increasingly being hospitalized as more mothers work outside the home.

According to Miss Maja Foget, Chief of the Nursing Division for the National Health Service, the Danes are comfortable about modifying policy according to their experience. They continually seek improvement and are flexible about adopting new programs and ideas.

"The Danes characteristically can improvise. Our way of cooperation makes life go smoothly because we can combine. We aren't dependent on rigid structure. We never go to the ceiling about something. We find a compromise. We are careful in our use of language to avoid the suggestion of pressure or force."

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The trend in Denmark is toward decentralization and more local responsibility. Increasingly, tax funds are directed to local authorities rather than the state. The 22 counties of Denmark are being diminished to 14 which are responsible to the local authorities and thus to the individual citizen to a larger degree than before.

Hospitals are under the Bureau of Inner Affairs. Child care institutions such as kindergartens, nursery schools and mother care are under the Bureau of Social Affairs.

Staff

Children's activities in play and in learning within the hospital are supervised by nurses, physicians, play leaders, care-giver nurses and by psychologists. Each psychologist sees up to 150 patients referred by the physician for screening and continues to work with a small percentage of those seen originally. She refers and consults with other staff members about the remainder. Hospital psychologists may, when appropriate, continue seeing patients after discharge. Glostrup is a community with many young families; many children come in with psychogenic problems. The psychologist conducts interdisciplinary meetings to share information gained during her interviews with parents and children. She also works with the nurses who teach children about diabetes to remind them of the psychosocial aspects of treatment and modify the strictly medical management of disease necessary if the patient is to cooperate in his self-care,

The psychologist sees all diabetic children to assess their ability to comprehend and profit by instruction and may also help the child maintain his friendships while managing his disease by showing him how to juggle his diet to allow an occasional pizza with friends without jeoparding his well-being.

Each ward has a Play Nurse assisted by Care-giver Nurses and students in Care-giving Nursing. These young women are the Danish counterparts of the British Nursery Nurses and the Swedish Child Nurses. They are trained to manage the common developmental needs of young children in nursery school or hospital.

Half Time Shifts in Denmark

In Denmark, half time shifts for nurses mean one week on duty followed by one week off duty. This has advantages in that a family can vacation together or catch up on household and family tasks, but for the family with young babies, the longer hours of separation may be difficult to tolerate, and the longer stay in the day care center operated on the grounds for staff children may be less desirable for that age group than a system such as Amersham's.

THE HOSPITAL AND PARENTS

Parents do not live in as a practice in Danish hospitals. There is little demand for such services. Sixty percent of Danish mothers work outside their homes. Day care has a 100 year old tradition. Parents share household and income-producing tasks. Family time together is usually spent doing things together. Parents, unaccustomed to "just sitting around" at home, are not likely to do so in the hospital.

Opinions within the health care professions vary as to the importance of parental presence. At one hospital where self-care teaching was emphasized, a head nurse said: "Parents interfere with the teaching. We are very good at explaining just what is involved in a procedure to the child. Often, just as he understands and accepts, along comes the parent bringing her own fears. She makes a fuss and then all our work is undermined. That's why we don't allow parents to see patients on the morning of surgery."

Danish national concern for children's well-being in the hospital takes the form of heavy self-imposed taxation to provide quality care in quality facilities. Living-in is viewed by many professionals and parents as not necessary nor worth the attendant disruption of home or hospital routine.

The attitude toward parenting-in in Denmark is illustrated in the following statements:

A Pediatrician: "It is not good to keep parents at the hospital unless you give time to preparing them. Otherwise there is continual irritation between mother and nurse. It takes time ... it is more time-consuming to discuss leukemia with parents than it is to treat leukemia in the child. No one is better than the mother for children with chronic diseases, but conflicts arise when orientation is neglected. If you bring in parents you must allow time to talk with them, and they are demanding. Alternate solutions are day treatment, nearby hotels for parents so that they can be called as needed. In Denmark the trend is not toward parent accommodation."

A Danish nurse: "Some parents just won't leave until they have made their child cry; they seem to think that until he cries he doesn't understand that they are going. They keep saying good-bye and coming back until they have him upset."

"The surgeon plays operating room with the child before surgery to help the child understand what will occur and to develop trust and familiarity between himself and the child. A parent staying would interfere with this relationship."

A hospital psychologist: "If you use the parent to support the child you create a new problem ... you must prepare the parent to prepare the child, but then you have a scared parent performing the task instead of a confident, assured experienced staff member. Which helps the child most?"

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Parent Encouragement

When Danish children are hospitalized, their parents are reminded to visit regularly and often. Brochures state that frequent daily visits help the child more than do long week-end visits. At Hillerod the head nurse arranges her schedule so that several evenings a week she can be available to families and fill them in on bits of information about their children that delight them. She offers counseling to families and children for whom the separation is especially painful. Parents there, as at Glostrup, are encouraged to stay through the supper hour to feed toddlers their evening meal, tuck them in and stay until the children go to sleep before leaving for the night. Living-in was neither requested nor encouraged at any of the Danish hospitals surveyed. A few beds available for the use of nursing mothers are reported to be seldom used. The Danes provide the best in buildings, equipment and staff; like to leave care to the professionals, who by and large agree with the parents.

While a public health nurse complained that it is difficult to do preventive mental health with young families who "do not like to look at unpleasant things, nor to talk about them until it is too late to take care of the situation easily," a child psychiatrist said one of the reasons so many children are seen in pediatric units of the hospital with symptoms of a psychogenic nature is that parents have no place else to turn: "Danish parents don't beat their children; they hospitalize them when they misbehave." Many children are admitted with such psychogenic disorders as enuresis, colitis, asthma, and aphasia.

To summarize, encouragement for parent involvement with hospitalized children in Denmark is mixed. On the one hand, parents are advised and encouraged to come visit often, but come as visitors. Their children are dealt with by professionals. Children's needs are the concern of the experts at the hospital while they are patients and, in some cases, after they leave. This idea is acceptable to young families who see disruptive behavior as unnatural and are accustomed to sharing the care of their children with others almost from the beginning of life.

BRIS: CHILDREN'S RIGHTS COMMITTEE

To educate the public about children's needs for early emotional support and bonding, an organization of predominantly professional people has been formed, THE COMMITTEE FOR CHILDREN'S RIGHTS. The name in Danish is Borns Rettigheder I Samfundet and goes by the acronym, BRIS. BRIS campaigns through the media as well as through study groups. Members serve as child advocates within the system to acquaint the government of violations of children's rights. The organization has shown the Robertson films on hospitalization and separation, and arranged television appearances by such crusaders from U.S./Uri Brofenbrunner, John Holt and Marshall Klaus.

I spent an evening with Dr. Torben Bille, a pediatrician and active member of BRIS, and his wife. Dr. Bille heads a BRIS work group on "the child in the hospital" who talk with administrators, local government officials, hospital staff members, and parents about the importance of early bonding. He is joined by a number of other professionals, physicians, nurses, social workers, and teachers who share his sentiments.

"We meet and advance one hospital ... then we point to them and say: 'Look what they are doing and see how well it is working.'" One goal of the group is to add clinical experience with hospitalized children to the curriculum for future nursery school and kindergarten staff members. By having them devote one year to this aspect of education, BRIS hopes to affect their future careers as parents and as teachers.

HOSPITAL VISITS

Four institutions vere visited in Denmark: Copenhagen County Hospital in Glostrup; Frederiksborg County Hospital in Hillerod; Rigshospitalet (the University Hospital) in Copenhagen; and Vangede, an institution for the retarded, outside of Copenhagen.

Glostrup Community Hospital

Glostrup is situated in a new suburban community outside of Copenhagen. The building, of Finnish design, is shaped like a W. The beauty of its design, the space, and the decor are breathtaking. The lobby is hotel-like, with shops, banks, post offices, and other services in a giant, art-filled space. One wall is devoted to an outsized wood carving depicting little children coming to Jesus and the disciples, all nude.

A bornparking (child parking) for children of visiting parents occupies a large part of the lobby and is supervised by a cheerful young woman who manages to give tender affectionate care to her charges while simultaneously constructing a number of wall decorations. Children are at tables drawing, building with blocks, and playing games. A playhouse has been created in one corner of the space, complete with cardboard walls, curtained windows, and a fishnet roof to afford children a sense of privacy without blocking the playleader's view. Instead of child-sized furniture in the playhouse, brightly colored foam blocks and slabs in a variety of shapes allow children to build their own furniture. When they are finished, the area is quickly restored.

The patient areas are bright with color, and many windows bring in as much light as can be captured. Light is celebrated in Scandinavia; with so little sun much of the year, every possible device is used to bring light in when it is available.

Children are grouped in rooms with plenty of space. The furniture is modern and permits each child to have his own things nearby. Toddlers' play and eating space, adjoining their sleeping room, is lined with low toy shelves and furnished with small round tables and chairs, high chairs, and rocking chairs for adults. Appealing mobiles and works of art mitigate the sterility of the hospital. Small pieces of sculpture, plants, candles and bric a brac stand on low tables in the corridors and waiting areas; children's beds are hung about with their greeting cards from friends and family. Before 2:00 o'clock few mothers are visible, and the youngest children are silent and appear dazed, but in the afternoon as parents arrive to play and feed supper, the room begins to resound with the babblings and pounding one associates with children of this age.

Glostrup's pediatric service specializes in diabetes. A case load of approximately 80 families, receive in-hospital and out-patient services in connection with this disease. Children aged three to fourteen are in four-bed wards. Play takes place in the rooms, in adjoining day rooms, and in the large, well-equipped school, crafts, and hobby center.

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Toddlers in Denmark are called "legeborn" which translates to "play age." Their toys are plentiful and available on low open shelves for them to help themselves. As children grow older, they are expected to use play for learning and constructive activity. Inventive devices have been developed by the professional staff to help teach the children to manage their own care. The philosophy in this hospital is that knowledge of the disease is essential. The Nurse-Matron (head nurse) who developed many of the teaching materials says: "We believe that once the child understands his disease fully and knows how to manage it, he can lead a normal life without feeling sorry for himself."

Parents and volunteers participate far less in the play program or the preparation aspect of pediatric care than in the United States or England. Play and preparation are the province of the physicians, nurses, or psychologists. Patients get a lot of emotional support. For example, no child goes alone from one area of the hospital to another; his own nurse accompanies him.

The school room is presided over by a male teacher supplied by the school district. He has one assistant. School age children from seven to fourteen must be in the classroom or in bed every school day between 9:00 and 2:00. In the several rooms are an impressive variety of learning games, audio visual aids, and teaching machines so that children can pursue learning with a maximum of independence. The teacher maintains good linkage with the public schools.

Adjoining the school room is a well-equipped crafts and hobby center. Children may not drop in but must arrange through their ward staff for craft times. Parents, except for those of long-stay patients well-known to the staff, are barred from the crafts suite. The equipment of the center includes sewing machines, a piano, a sand box, a work bench stocked with all kinds of carpentry tools, and a storage closet stocked with all kinds of games and crafts materials. The young man who supervises the area keeps a large notebook, each page illustrating a project that a child can choose. A patient can leaf through the book to decide what he wants to try each day. For new patients, the book allows a non-threatening introduction to the area. During the visit immigrants from non-Danish speaking countries were coming into the hospital. The project book was especially useful for communicating with them.

One of the nurse-matrons uses cooking projects to teach older children to manage their diabetes. They cook, using their own cook books, weighing and preparing their own meals in a kitchen adjoining their ward. She has developed age-appropriate booklets and video-tape cassettes. Similar devices used by the nursing staff teach children about injections. A loose-leaf notebook shows parents and older children what is going on in the body of a child with diabetes. For the younger children a colorful cartoon book *"Pers and Lisa Have Diabetes"* explains in simple language what the diabetic child can do and can eat. The plot includes an episode where Pers eats what he shouldn't one day and falls sick. He is confined to bed and Lisa finds someone else to play with. Pers recovers and having learned his lesson, watches his diet more carefully, avoids future illness,

and is able to resume normal play with his friend, Lisa. The chief physician did the illustrations and the nurse wrote the text. The nurse who developed this teaching program abandoned group teaching after observing that everyone learns at a different rate. Individual teaching took so much time that she found herself putting in fifteen-hour days before developing the books and audio-visuals that now allow parents and children to teach themselves and each other on their own.

Hillerød

The environment at Hillerød is quite similar to that of Glostrup. The buildings are older, but pleasant, colorful, and light. Wards and corridors are hung with interesting mobiles assembled by children or staff members. A central play area finds children in beds or sitting at long tables with the Play and Care-Giver Nurses busying them with paints and other crafts. Each patient bed is fitted with a white wire basket hooked over the end containing that child's personal possessions.

One of the nurses has devised a way of teaching her patients about disease and injections with a large wooden figure. A panel over the abdominal region when removed, reveals brightly painted insides. Accompanying this are wooden representations of medical instruments the child may use to give the wooden man injections.

I observed on a unit at Hillerød a ward of 18 patients, 3 - 10 years old. My guide was the head nurse, Hanne Vesterdal Jorgensen. She works to make the hospital a comfortable place for children and parents, staying for one night shift a week in order to speak to parents who work and don't come in until after 3:00. Children use the intimate form of address and call doctors and nurses by their first names. She asks parents to use first names, too.

Each nurse, student, and aide cares for three rooms to insure continuity of care, changing assignments monthly. Mrs. Jorgensen asks parents of children under six to come at bedtime, tuck their child in, and stay until he or she drops off to sleep. Because she, as a mother herself, enjoys hearing reports about her own children from their day care teacher, she collects anecdotes about their children to interest parents and keep up their interest and feelings of parenthood. She believes that as so many parents have worked most of their children's lives, such stories not only delight them but also increase their understanding and awareness about child development.

Like so many others interviewed in Denmark, Hanne Jorgensen was pessimistic about the prospect of parents living-in. She has succeeded in increasing the numbers of parent visits and their calls to children several times during the day. She is also an active member of BRIS, the Children's Rights Organization.

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Rigshospitalet (University Hospital)

The pediatric unit of the University Hospital is housed in an old stone buiding to the side of the elegant new high-rise hospital that occupies the center of the grounds. Although the rooms and corridors were darker than those of the newer hospitals visited, the spirit was bright. Children were occupied with play or school accompanied by play leaders and Caretaker Nurses. They rove the halls freely and appear to be at home -- even the dark-eyed young Greenlanders who are carried by plane alone from their homes and families to Denmark with no language and little more to identify them than numbers on their backs. The Director of Nurses notes that their adjustment is amazing under the circumstances and attributes their acceptance and trust to their early mothering, where the practice is for mothers to carry children strapped on their backs during their first years.

Because of staffing problems, this hospital is experimenting with a five-day week treatment program. All children go home on Friday and all staff members take days off at the same time. The director of nurses complained that it is hard on the children in that tests must begin almost immediately upon admission without allowing a settling-in period.

Rigshospitalet has a patient population of 97 children from all over Denmark and Greenland housed in seven wards. Only the tiny babies are grouped together according to age. Children in the other six units are grouped family style. "Grouping all two year olds together leads to a factory feeling. Caretakers begin to change diapers or spoon in food according to a schedule that destroys the feeling that we want children to have here," the Director of Nurses explained.

Play takes place all over -- in the day rooms, the wards, and the corridors. Playthings are available, ample, and attractive. Children who can be up are dressed and out of their wards, involved in a variety of activities. Rooms and corridors are decorated with children's own creative efforts -- mobiles and three dimensional wall decorations.

A play leader is assigned to each of the wards except for the infants' ward. Two play people work in the isolation unit, and there is one kindergarten teacher.

As at other hospitals in Denmark, psychologists play a major role on the staff. They interview each child and pass on the results of their interviews to the play staff as well as to the nurses along with suggestions for individualized, helpful play. Doctor play is discouraged unless a knowledgeable adult is attending and interacting. The psychologists believe that such play without adult supervision is potentially dangerous to the children -- increasing rather than reducing fears.

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Vangede

Vangede is an institution for the care of children handicapped by retardation. Located outside of Copenhagen, the low attractive buildings are grouped close together on large grassy acreage. Three hundred resident patients eat and sleep in family size groups, each in their own house. In addition to these cottages, a number of larger buildings house the occupational therapy program and pool, the school, and an assortment of crafts.

Self-help is an important aspect of the program at Vangede. Children eat in small groups to develop social and feeding skills. They are encouraged and helped to find their way alone about the grounds. An exciting "Adventure Playground" with marvelous climbing structures, lean-to's, bridges, hammocks, and tunnels occupies a prominent place on the grounds. There are structures for house play and obstacle courses built out of old tires, milk trucks, rope nettings strung between trees, and oil drum tunnels for children to learn to help themselves to mobility and exploration. All the equipment is made out of discards and put together by the patients and their caretakers.

Vangede is a demonstration center, a respite center, and a day care treatment center as well as a resident center. It is designed to help parents keep their children at home (rather than institutionalize them) by relieving parents and to add richness to the children's lives without removing them from their families permanently. The cost per child for this well-equipped, well-staffed center is $10,000 a year.

The trend is to give parents so much help that they can keep mentally retarded children at home. Help includes respite care. Upon the birth of a retarded child, medical staff members inform the institution and counsel parents. The hospital keeps the child for the parents while they come to terms with facts. No child is ever sent home without preparing the family. If the parents decide to place their child, they are told that they must visit regularly and that placement cannot be forever. Too long a lapse between the birth of the child and homecoming leads to institutional placement.

There are ten centers for retarded people in Denmark. Vangede is the children's section serving the Copenhagen district.

Of the 1400 children served, 1100 live at home with the center helping by providing schools, kindergartens and recreational programs. Services are coordinated by 18 out-patient social works who make themselves available to the families. Each home that cares for a retarded child gets 800 Kr, tax free, per child to help the family cover all the special equipment needed to keep the child home. In addition, a home nurse is available to the family regularly.

The Copenhagen area is divided into districts and each social worker has parent meetings with speakers and programs to interest the families under her wing. In addition, there is a Holiday Home (a relief home) that

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accommodates twenty children to allow families who give home care the opportunity to take vacations while the children have respite care. The setting of the Holiday Home is beautiful enough to make the vacation a special pleasure for the children who stay there while their parents are on holiday, too.

For the children who live at Vangede, an "Auntie" system of week-end home care given by volunteers was tried, but abandoned after awhile because too often the children were dropped after a very few visits, and were painfully disappointed. Staff members who work at Vangede do often take children home with them for occasional week-ends away from the institution.

Dr. Bank Mikkelson, the director of Vangede, is a lawyer and a Ph.D. He has succeeded in making the community, the parents and the hospital aware of humane ways of dealing with mentally retarded people. They are no longer "forgotten children" stuck out of sight in the country. Today, only about five out of the 300 resident children have no special person to come visit them from outside.

There is a strong parent organization and parents are invited to participate in all conferences. Each cottage has parent representatives who sit in on all house meetings. Visiting is open with parents encouraged to feel free to come at any time.

An active chapter of Aid to Retarded Children promotes good liaison between the parents and the professionals. Together they exert pressure on the government for funds to offer good service.

The philosophy of the government as well as of Vangede is to encourage parents to keep children at home in the early days of their life. Between one and two per cent of the population of Denmark is retarded. The organization offers, rather than forces, acceptance of the diagnosis of mental retardation to new parents; A.R.C. and social workers help the family talk and offer home services that must take the place of institutional placement for infants because there are not enough places. Vangede refuses to overcrowd.

Authorities at Vangede stress independence, mixed age groupings, mixed sexes and family style living. The institution is well staffed, mostly with young people. The policy of social concern in Denmark, while very expensive, does much to create jobs for the young.

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SWEDEN

NATIONAL WELFARE SYSTEM

As early as 1774 the first pediatric textbook in the world was written by Nils Rosen von Rosenstein who recognized that the most important way to lower the infant mortality rate (only fifty per cent of Swedish children survived to the age of five at that time) was to educate mothers in childrearing. His pioneer work contributed to the establishment in 1845 of the world's first chair of pediatrics at the Karolinska Institute in Stockholm.

Although a first attempt to organize preventive child care was made in 1901 on private initiative, there was little further development until the creation of the national welfare system came about in the thirties. The special program for preventive child health began in 1938. The infant mortality rate drops steadily. Sweden has the lowest in the world.

In Sweden, benefits begin before birth. Prenatal care and all maternity care is free at nearly all maternity hospitals. Benefits from compulsory national insurance are additional to any contributions from employers or private insurance companies. All mothers receive a grant from the government of $209 at the child's birth and $232 a year until the child becomes sixteen years old, or eighteen if the child remains in school. If the mother is employed during her pregnancy, she receives a six-month leave of absence with a salary-based maternity allowance for six months. She may take another six months with her former job guaranteed but without salary if she is able to do so. Parents of handicapped children cared for at home receive State grants.

Hospital care is free of charge and consultations at out-patient departments and with practitioners are covered for the most part by compulsory insurance.

Sweden has a population of eight million and a nationwide network of about 1300 child welfare centers charged with carrying out the preventive child care program developed by the National Board of Health and Welfare in close cooperation with the medical community.

Welfare Centers are located at pediatric hospitals or in buildings of their own and serve about fifty per cent of the child population of Sweden. Registration is entirely voluntary, although all new births must be reported by the maternity hospitals.

The service is free to the family; the annual cost per child is about $11.00, shared equally by the national and county authorities. 96% of all children are registered during the first year of life with a steady decline until the figures are 22% at five years.

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All registered mothers get a home visit by a nurse within two weeks after delivery. They make their first visit to the center sometime between two to six weeks and thereon the visits average from four to seven for the first year and between one and two for the following years until school age. Service at the centers is purely preventive including medical examinations, vaccinations and advisory work. If the child is found to be sick or a problem comes to light, the family is referred either to a pediatrician in private practice or an out-patient department at a children's hospital for further examination and treatment.

The centers are staffed by a Pediatrician holding a part-time appointment and full-time nurses, specially trained, whose preparation and responsibilities are like that of the Pediatric Nurse Practitioner in U.S.A.

Advice about nutrition, health and everyday problems of childrearing are the realm of the nurse, available every day by phone. Additional advice is offered through pamphlets. In large cities child psychologists have been appointed to the welfare centers and attempts have been made to arrange group discussions with parents of children with simple behavioral problems such as eating, sleeping and toileting disturbances. The psychologists also assist personnel toward increased understanding of behavioral and psychomatic disorders.

Breast feeding is encouraged. About 90% of the newborn are breast fed in the hospital. There has been an increase in the tendency to seek advice on minor practical problems of child rearing as the living standard has become higher and nutritional problems have declined. The nursing staff provides the major part of these advisory services.

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The hospitals visited in Sweden included the Karolinska Institute, Samariten Hospital, St. Goran's and Umea.

PARENT ACCOMMODATIONS

Sweden hospitals offer most complete physical accommodations for parents who choose to live-in. Three programs I visited set aside space that they called Parent Hotels ... in units containing four or five bedrooms with baths and amply furnished with bed, lamp, desk and chair adjoining a common living room and kitchen. Some have laundry and sewing facilities. Some hospitals make no charge for the rooms; some charge $2.00 a night.

St. Goran's

St. Goran's has, in addition to the parent suite, several other arrangements whereby parents can room-in with children or sleep in a room adjoining their child's. Their booklet describing the planning of the hospital states:

> ".....In planning, we have taken into account parents' desire to stay at the hospital and every unit has one or more rooms for parents-with-patient accommodations."

The pre-admission booklet sent to parents to prepare them for their child's hospitalization makes no mention of the parent rooms. In fact, it reassures the parents that they should not be distressed if their child cries when they leave as the child usually stops before the parent is out the front door. The booklet urges parents to visit often.

Karolinska

At the Karolinska Institute parent apartments are located on the top floor of the building and consist of three four-bed rooms, a kitchen and a living room with television. Parent quarters adjoin the nurses' lounge. In the rehabilitation center 300 meters from the Children's Hospital are four more two-bed rooms for parents. A few chaise lounges can be procured to set up in patient rooms. No parents were in residence at the time of my visit.

> "The hospital was built before the need was discovered for many parents to stay with the children. Most parents are told to visit their children every day. As our play therapy department has become more efficient, the need felt by the children to have mother or father around all the day and the night has greatly diminished and it is tremendously effective complement to the visits of the parents. The play therapy changes the whole atmosphere of the ward and much of the anxiety of the sick children

as well as of the parents has disappeared." *

Dr. Lind suggests that parents and nurses must be re-educated about the importance of parent stays with very young children. "We doctors taught nurses that parents were not important and the nurses went along with us. Now, we have changed our minds. The nurses are used to being without parents, so changing takes a little time." He, himself, believes in telling parents directly when their child needs their support and they should stay.

Umea

In Umea, in the northern part of Sweden, the hospital facilities are in a parent apartment similar to those at St. Goran's and the Karolinska, located on the ground floor and adjoining the play therapy unit. An intercom connects them with the children's units. Few parents take advantage of the rooms. One staff member predicted that when there is a new generation of parents and child nurses who are educated regarding the young child's need for attachment, hospitals will offer a welcome to parents so convincing that more will make use of the programs.

The major thrust in preparing such a new generation comes through the schools of nursing and through encounters between families and health visitors who follow mothers and children from pregnancy through the fifth year of life.

Samariten

Samariten Hospital in Stockholm allows parents, but overnight stays are de-emphasized. A room just outside the infant unit is provided at no cost and meals are free. Mothers may also share two-bed patient rooms with children. The hospital has no rules except that the space is for mothers only. The dormitory for nursing mothers has room for 2-4 mothers and this space is mentioned in the hospital's brochure. There is a parent kitchen on each floor also.

This is the only hospital visited with a routine system of pre-admission calls. The social worker and nurse make an in-take home visit to each family anticipating admission. They introduce themselves, pick up parent and child concerns and on their return to the hospital hold a planning conference with inter-disciplinary staff members to develop an individualized care plan based on findings from the home visit. At this visit, living-in is discussed, but parents are not urged to consider staying, especially if other children are in the home.

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*Quoted from private correspondence from Prof. John Lind

PLAY IN SWEDEN

History and Philosophy

The four hospitals visited in Sweden have well-established play programs staffed by professionals assisted by students. All offer play on the units, in separate play quarters, and in waiting areas.

Hospital play programs began in Helsinki, Finland in 1909 through the efforts of a Finnish kindergarten teacher, Bari Luther. The idea soon spread to Sweden and play activity began in 1912 in The Crown Princess Lovis's Nursing Home for Sick Children in Stockholm. Up to the 1930's, kindergarten teachers and volunteers provided play and occupational activity for hospitalized children without pay. Such programs were most common in sanatoriums and long term nursing homes, and often volunteers also had to help school-aged children with their education.

In 1930, the first salaried kindergarten teacher was employed in a hospital. Today, play activity has spread to many children's hospitals and clinics, although there are still some hospitals with no organized play or other occupational activity for patients. Even where play leaders have been hired some administrators are slow to provide space and material resources, I was told.

Nevertheless, the hospitals I visited in Sweden demonstrated carefully thought-out and well-equipped play programs. Play receives careful consideration in Sweden. Play Leaders speak of stage-setting as a device for securing goodwill and cooperation from visiting children and their families during their first encounter with the institution. They carefully select appealing toys for all areas where children might wait. They create or collect interesting art work for corridors, elevators, and wards. The emphasis on real achievements -- baking real cakes in real ovens to serve visitors, making wooden name placques for oneself or for friends and family at the work bench, decorating the hospital with exhibitions of hospital-related art -- lend a dignity to children's activities that broadens the concept of play from mere "keeping them busy" to enhanced self-esteem. Play activities develop muscles, prepare children for new experiences, or add to their mental, physical, and psychological growth. Games of skill or chance help children play out some of their annoyances and anxieties symbolically. Creative dramatics allow mastery of hospital experiences.

In many of the hospitals, children's wagons are used to transport small children. A line-up of red delivery wagons along a hospital corridor makes a statement quite different from a line-up of wheel chairs and gurneys.

Coat and shoe storage racks for all staff and visitors outside children's units keep street dirt from entering the children's play areas.

Children in Swedish hospitals are grouped family style with mixed ages rooming together, except for the very young babies. All children have storage space for their own personal playthings. Babies and younger children usually play in attractive dayrooms adjoining their wards so

that they are not overburdened with too many different encounters. Older children, who have different needs, are encouraged to leave the wards and participate in separate play areas on separate floors. These areas include gymnasiums, outdoor play parks, and rooms for a variety of exercise, therapy, and hobby activities.

In Sweden play is seen as more than diversionary activity sporadically offered to pass time. Play equipment is chosen and presented with as much care as is any other equipment used in the treatment and care of children. Play is directed by trained professionals who assume responsibility for play care plans as well-thought-out as are the other patient care plans.

"We cannot be everywhere to help the child handle the hospital experience, but we are there symbolically when we make the places pleasant and attractive. We make the institution softer and politer through the toys we have for children to use," says Ivonny Lindqvist, Play Leader at Umea. Her sentiments were echoed by play leaders at the other hospitals chosen for study.

While space and equipment are impressive, Mrs. Lindqvist warns, "It is dangerous to think you must have elegance to have a good program. Children can play under beds and tables when the spirit is present." She remembers fifteen previous, makeshift headquarters for play in the hospital, when all today's sturdy and beautifully crafted equipment was prefigured by things improvised out of cartons and crates but available for children's use.

Staff Education and Roles

Today's emphasis on purposeful play as part of hospital therapy calls for specialist training in addition to the pre-school teacher's education. Teachers' colleges in Stockholm and Malmo offer a one year course to qualify credentialed teachers as hospital play leaders. This training prepares a play director to bring along the rest of the staff, acquainting them with the value of play and of choosing appropriate playthings for patients.

The in-service educational aspect of the Play Sister's role is most important, because many children are tucked away in adult units and might be overlooked unless nurses make special efforts to meet their play needs.

Child Nurse Training

The Swedish equivalent of the United Kingdom's Nursery Nurse is the Child Nurse. Today in Sweden ninety per cent of all high school graduates choose to continue their education. Many young people elect to study Child Nursing. The group enrolled at University of Stockholm at the time of the visits included seventy-five young women and one young man all between the ages of sixteen and eighteen years. Child Nursing, a two-year

program that is step one on a career ladder, helps educate young people for parenthood as well as for nursery school and hospital assistant positions. At University Hospital in Stockholm, a nursery school teacher and a nurse educator team teach a curriculum that includes family planning, beginning concepts in Child Development and Child Health. Students first participate in a pre-training assessment period to see how they like working with young children and to be assessed as to suitability for the job. If all goes well from both vantage points, the student moves into a two-year course and finishes as a certified Child Nurse. During training, students participate extensively on the wards, in the playrooms, and in the hospital operated play groups for siblings, clinic patients, and staff children. St. Goran's uses students from this program throughout the hospital and clinics.

Step two on the career ladder includes two and a half years of experience, followed by more education, leading to an R.N. After more field experience, the student may again return for graduate work in psychology and sociology and receive a graduate degree. Liberal arts education is built into the curriculum throughout in order to round out the student's personality.

The play therapy department of the hospitals visited offers observational and clinical experiences to students in other fields, such as Special Education and University level courses in Psychology, Medicine, and Nursing.

HOSPITAL VISITS

Samariten

Sykbradhusset Samariten is an old building on the grounds of a hospital complex. Samariten has beds for 120 children -- infants through adolescents, and is set amid gently sloping grounds studded with outcroppings of rock and trees which were, at the time of this visit, covering the ground with orange and yellow leaves. A play yard near the entrance gives the first glimpse of the hospital's attitude toward children. A slide set into a hillock, a small wading pool, some challenging rocks to climb, but no fence ... boundaries occur naturally because the yard is strategically arranged for easy supervision and containment.

Over the front door a frieze depicts a scene of children. The building was originally erected with funds raised by Jenny Lind during an American concern tour. The children, in mixed age groupings, family style, are up and around, dressed in their own clothes whenever possible.

The corridors and patient areas are light with lovely color, bright pictures -- many of them children's art work -- and cozy groupings of furniture. Small alcoves and corners are fitted with small round tables and bright chairs inviting a chat. Playthings within children's grasp are in use.

Space is generously allotted to children's play. Outdoors, a woodsey plot just beyond the front entrance offers slides, climbers and natural terrain for play. Inside play space is integrated into the children's rooms. In addition, the entire top story of the hospital is given over to the play program. Here equipment fills two large rooms, an equally large hall, a kitchen and, a homey, wood-paneled conference room with eaves, window seats, and a fireplace for stories and quiet chats. Only twenty children at a time are allowed in the playroom. On the children's units, large storage cabinets are stocked with toys for nurses and parents to dispense for children who cannot leave the wards, and a large variety of well-used but well-cared-for play and school equipment stands ready and inviting. Mobiles and wall decorations fashioned of interesting and unusual materials catch the eye. Children's paintings of hospital themes adorn the walls.

Samariten operates its play program with only two full time play leaders for 120 child in-patients. Miss Ulrica Spens, a former nursery school teacher with a degree in Occupational Therapy, has directed the program for more than seventeen years. Her years of staff development have resulted in good collaboration with the nurses who use the well-stocked stores of toys on each unit to manage play for the younger children, and for health-care teaching.

The play staff selects and maintains equipment in the out-patient departments as well as on the play floor. They trundle their equipment around the hospital using infant bassinettes and shopping carts as conveyers. After children are acquainted with play staff members, the older patients make their own appointment to choose activities which are selected with the careful consultation from the play staff to work out a suitable play prescription for each child.

Each head nurse decorates her own unit and corridors to make them appealing to children.

Two public school teachers, a part-time psychologist and one full-time social worker serve the in-patient departments as a team.

Pre-admission home visits are routine. The social worker and a nurse call on prospective patients during the week prior to admission to answer questions and ask some of their own, such as: "Why do you think you are coming to the hospital?" "What does your child think about the hospital?" "What do you want the hospital to do for you?" The team offers the family written guides on what to expect and what to bring. Information from the visit is shared with the rest of the staff at ward conferences and the group plans for the child's forthcoming admission.

Equipment in the top floor play department at Samariten includes twelve looms of assorted sizes, sewing machines, an adult kitchen, ping-pong tables, trays of sand, buckets of dirt and water, papier mâché, finger-paint, easels and water colors, clay, wheels and kilns, an extensive library, whole walls of shelves stacked with games of every description, hobby and crafts materials, tools and workbenches for carpentry, props for dramatic play, dolls and doll houses of all sizes, and a real broadcasting

system to allow play leaders and children to transmit stories and dramas to the bedside of children on the floors below.

Large looms, sometimes reinforced to make the pull even stronger, are used for children with obesity problems who respond much more positively to weaving a rug or a bag than they would to callisthenics. For diabetic children who need to maintain a stable regime of exercise each day, ping-pong and other active games help not only for fun and release but also to regulate their energy expenditure.

The therapist at Samariten believes that children reveal their concerns, ask their questions, play out their own dramas, and work out their own therapy if the right materials are supplied and caring, observant, well-trained staff members are available for observation and consultation. For example, messy and organic supplies are displayed and readily available for children with problems such as encopresis which are helped by the constructive use of mud, sand, water, finger paint, and papier mache. Outdoors, children may climb hills and slide down, splashing into a wading pool in the summer or sliding on ice in the winter. Carpentry also allows release while life size or miniature dolls stand ready to help children play out concerns therapeutically.

Karolinska

This hospital, also set among leafy, sloping grounds, is part of a complex of hospitals. A warm, inviting atmosphere is enhanced by the use of color, sculpture, paintings, and plants that dispel the depersonalized institutional air. When a guest enters an office, the host lights a candle.

Karolinska Institute operates its play program from a central ground level room lined with equipment that the play staff transports to the children on the wards as appropriate to their needs. Larger equipment, like the looms, can be used in the play center or moved to the units as needed. The play center is used for crafts by patients, play staff, and students planning activities and creating decorations for the units.

Karolinska has developed booklets describing hospitalization through the eyes of small children. One version, mostly pictures, is for two-to-three-year olds; the second is for older pre-schoolers. These booklets deal not only with "what to expect" in terms of hospital routine and play activities, but also weave a story of the young patient's anger and shyness in the face of his mother's daily departures and his encounters with other children.

Karolinska has a play staff of professionals whose work includes the supervision of students.

The Lekotek

Another program, somewhat related to the Institute in that it shares the professional services of a psychologist and a pediatrician from Karolinska

is the Lekotek or Toy Library.

The Lekotek is housed in two buildings on the King's Grounds in a sylvan setting overlooking the water. This program, financed by the Boy Scouts of Sweden, is a library and school program where toys are used to diagnose and treat autism, aphasia, and other communication- and hearing-connected problems of young children.

Toys at the Lekotek are used to identify symptoms of autism, speech lags, or other deviations. Following the screening, parents and staff members confer and determine a program for use of the library's toys as additional stimulation for the child. This service is free and includes parent counseling. Some tests for determining residual hearing ability and communication disorders that might be present in an infant have been developed and are in use throughout Sweden and in a number of other countries. From research at the Lekotek involving parents and children some new programs for encouraging the development of mother-child communication immediately following birth have evolved. For example, at Karolinska, new mothers are provided with canvas slings to hold their babies so that speech and croonings go in a direct line to the baby, and the infant can also observe the mother's lips and eyes as verbal communication between the two begins.

St. Goran's

St. Goran's is a new building within a complex of medical buildings as beautifully designed as museum of modern art. The giant lobby is bordered by wide, low comfortable seats big enough for a parent and child to sit together. Wheeled vehicles for transporting patients are available, but stored behind an attractive lattice partition so that visitors are not immediately confronted with hospital equipment. The lobby houses bistros, banks, a post office, and a barnparking (play groups that care for well children while parents visit patients or attend medical appointments). Walls are decorated with hangings and woven murals, sculpted, and painted, depicting scenes about children. One handsome tapestry depicts children's experiences in hospital or clinic. A giant, brightly colored Rube Goldberg-like sculpture dominates the lobby, rising at least ten feet, the size of a small house. This mobile sculpture, set in a pool of water, has trigger controls a child can operate to turn on the water which activates paddle wheels, opens windows, causing funny faces to pop out, and setting in motion numerous other captivating gyrations.

One per cent of the cost of every public building in Sweden must go to its art and decor. St. Goran's was a very expensive building, and one per cent bought a lot of art.

St. Goran's is built around courts so as to allow direct sunlight into all patient areas. These courts are equipped for play. Each unit has direct access to the playroof of the lower buildings. Three-dimensional movable abstracts decorate walls on a children's unit at their level ready to be poked or rearranged, inviting exploration, and manipulation.

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St. Goran's specializes in the treatment of handicapped children. The large swimming pool, gym, and occupational therapy rooms all have special adaptations to serve children with handicaps. However, all equipment is shared with other patients since exercise and emotional release take high priority at St. Goran's.

The pool features an adjustable floor, so that children of varying size and ability may use it. The occupational therapy unit has child-proportioned kitchens and housekeeping rooms with adaptive tools to allow handicapped as well as non-handicapped children to develop motor skills as they play out such normal household activities as cooking and washing up.

Additional rooms house looms for weaving, wheels and kilns for pottery work, carpentry, handicrafts, and even a small auditorium with a stage for impromptu dramatic productions.

St. Goran's with 229 patient beds, has space designed for play and storage for toys throughout the hospital. Play takes place outdoors on roofs and courtyards. Each specialty clinic, as well as the anterooms where children wait for x-ray, surgery, and other tests or procedures, are designed to offer play. One whole area at ground level is given over to playrooms and rehabilitation facilities complete with a pool with an adjustable bottom.

A playroom for visiting siblings permits parents to leave their well children while they visit hospitalized children. Space used by the psychiatric day treatment program doubles by night for in-patients who use the fireside room for songfests and jam sessions. One room with a stage where the day patients meet becomes available for young hospitalized children to use for impromptu dramatics in the evenings.

The occupational therapy unit adjoining the rehabilitation center includes a child-sized housekeeping center complete with a working kitchen.

Four classrooms house school activities with additional space provided on several of the wards.

Most children coming to the out-patient clinics play in a central waiting area but those with suspected infections wait in small isolation rooms. These curtained cubicles have beds so that sick children can rest comfortably while waiting to be seen.

The building is designed with varying levels and built around several courtyards. Some courtyards are used for play as is the roof level of the parking garage. The outdoor play areas are bordered with bushes, and offer ample space for wheel toys, for beds and buggies.

St. Goran's employs trained play leaders or nursery school teachers in every area of the hospital where children may be present, including x-ray and waiting stations. It is the job of these teachers to soothe and to prepare children for procedures. The booklet that St. Goran's distributes talks about Play Leaders as follows: "Play therapists on the staff of pediatric hospitals help decrease the stress of a hospital stay for the

child. They are of great help in relieving children's stress and anxiety before surgery and serve as part of the team as a child goes into the operating room. The play therapists were consulted about the design of the rooms."

Umea

Umea is a newer hospital with less greenery and more concrete than either Samariten or Karolinska. The ground floor play department opens to a courtyard equipped with climbing structures, slides, and sand pits. Bumps of plexi-glass skylights adorn the opposite side of the courtyard to satisfy the Swedish hunger for sunlight. The skylights serve the basement of the hospital.

The play floor and corridors were in full and boisterous use during this visit. Twosomes were engrossed in play in cozy corners. The play areas adjoin the parent apartments, so mothers are often around. Parents can invite their children into their quarters to visit. Accommodations are luxurious and well-appointed. Only one parent was in residence at the time of the observation and her reason for staying was that her home was too far away to allow regular visiting.

The attitude of welcome and understanding for children and their play permeates the institution. All the hospital waiting rooms are equipped with toys and decorated with art "so that even if we are not there, we are being kind through the materials," the Play Leader said.

Three teachers and a number of students involved in their four month pre-practice experience made up the play staff at Umea. Considering that the play program cares for more than 100 children each day directly and indirectly, the play staff is small. However, by giving careful attention to stocking all areas with playthings and by working with parents and staff members from other disciplines, the expertise of the small play staff is extended to reach many children.

When large groups of children come to the playroom, their nurse stays to help. Very young or disturbed children's nurses also stay in order to maintain familiar relationships. Play Leaders take playthings for very young children to the nurses so that the babies will not be unnecessarily burdened with new encounters. In return the Play Leaders help the nurses out on the wards, and also serve as their allies and advocates when the nursing staff is campaigning for something -- color uniforms, for example.

The play staff members work to maintain family ties by welcoming parents in the playroom. An apathetic mother is prompted tactfully by a Play Leader to appreciate her child's efforts. A mother watching her child at play can observe the Play Leader's techniques.

"It is easier to help if you are not so young," Mrs. Lindqvist says, "because you must talk to parents and staff with authority as well as kindness."

Color, light, tasteful and interesting decor are used extensively. Each waiting area and ward play space is unique but similar in its use of child-oriented art.

"We consider it very important that children are met by a friendly environment as soon as they come into the hospital door. What they see must invite activity. That's all we have here ... invitations," the Play Leader comments.

Materials from nature ... mosses, leaves, acorns and pine cone mobiles, reminders of the woods and the natural world outside ... are used extensively in the decor. Mobiles constructed from unlikely materials such as medicine cups, egg cartons, and styrofoam structures of all kinds, plus collages of lids glued in intricate patterns and swirls adorn the walls, tables, and ceilings. A clinic doorway sports a hanging of stuffed, multi-colored, multi-textured strands like fat bell pulls, each ending with a large bell.

Umea has seventy-five beds in the pediatric units plus an indeterminate number of children who are in adult wards. The play program serves approximately one hundred children daily, either directly or indirectly, by placing toys in areas supervised by mothers or nurses.

Brothers and sisters as well as parents can visit patients in the play area. The atmosphere is homey and comfortable. Children appear relaxed and absorbed in play while mothers quietly observe from the fringes as they do their own handwork.

Play equipment in patient areas throughout the hospital is chosen with the therapeutic use of the particular children served in mind. For example, in wards for children with eye problems, playthings feature interesting sounds and textures; children in orthopedic units have bed-height doll-height doll houses and similar equipment to allow both socialization and activity.

Each waiting area or day room on the hospital units that serves children has child sized furniture and storage for toys for the child patients in that area.

In the area reserved for play on the ground floor a large gymnasium opens to the right of a long, wide hall which can be divided into many smaller spaces. The adaptability of the space allows the play staff to arrange for the kinds of children they will see on any particular day. The gym and the corridor may be used for large muscle play, carpentry, block building and hobby pursuits. Space is so arranged that small areas can be screened off to make interesting alcoves and smaller nooks inviting small groups to form and encouraging the feeling of close companionship and privacy so important yet hard to find in a large institution. To the left of the corridor is a suite containing the director's office. A one-way vision mirror separates it from the playroom for younger children. The office doubles as hospitality center, conference-observation room and classroom for university students, community members, staff members and

parents who meet to learn about play and the hospitalized child. Observations of children at play trigger discussion. The play room is arranged in zones to invite children to group themselves according to their own interest. Two partitioned alcoves complete the suite. One contains a complete working kitchen, child-sized; the other a living room with low comfortable furniture. Throughout the play area, walls are honeycombed with storage shelves and cupboards, both open and closed.

A note on the Play Leader's bulletin board at Umea states: "The art of medicine consists of amusing the patient while nature cures the disease." Adherence to this principle is evident in the profusion and variety of play equipment throughout the hospital. Toys for children of all ages are placed in clinic waiting areas so that children are eager to return for check-ups, remembering, according to their parents' reports, the doll pram or the big truck rather than the finger pricks.

In addition to the standard play equipment one might hope to find in a hospital serving children, community organizations donate presents and surprises so that individual children may have their own toys whether or not parents bring them. Dolls, doll houses, and boxes of delicately handmade doll clothes afford children long hours of delight with materials more personal than even the best made commercial toys. Umea's program puts much emphasis on the personal, individualized approach to play, not as an alternative to group play, which is encouraged and amply provided for, but in addition to group play. Play staff members use shopping carts and baby bassinettes on wheels to transport toys from the play department to the wards.

Another home-like touch is the collection of antique and miniature folk toys displayed on glass shelves in the playroom. Children are encouraged to look, to ask about and to handle the things, on the theory that these pretties will remind them of their life on the outside: "My grandmother has a doll like this ....." Children too weak or too lonely for active play gain a sense of involvement through these pleasant associations.

In the living room corner of the playroom, low polyurethane foam chairs, child-sized and brightly covered in orange-red allow children who might be unable to do anything else to join the group. Just sitting on such furniture feels more like play than watching from a gurney or a wheel chair. On the floor, a thick foam rug covered with a swirling patterned terry cloth lets children who cannot walk maneuver and change their perspective in a comfortable, stimulating atmosphere.

The play equipment includes sand and water tables, puzzles and paints, as well as blocks and construction materials. Children with disabilities can have fun with the materials because standing boards with cut-outs allow children unable to stand alone to work in groups at the water tables and socialize with other children as they play. Sturdy low wooden buggies with sand bags to keep them steady allow children, who cannot otherwise manage, to ambulate as they push them along.

Doll houses are very important in this hospital. They form room dividers,

are used as play hospitals, and allow bedridden patients to play together by using bed height doll houses which open on two sides. Much of the furniture is hand crafted.

A fibreglass climbing structure for the younger children is shaped like a mushroom with a removable domed top. The lower part serves as a hiding place with round port holes to peek out of; the top can be inverted for use as a water table. The whole structure is satisfyingly large but lightweight enough to be easily moved.

The reading room, with polyurethane foam furniture and rug, is especially hospitable to children with cerebral palsy. Because many such children are seen at Umea, the library has a picture story book of a child with Cerebral Palsy who comes to a special treatment school. It is entitled *PLATS FOR VANNA (Place for Vanna)*.

Toys for the expression of direct aggression are absent. Release comes about through the use of games such as "Mousetrap" (highly recommended) and through activities such as cooking, washing up, painting, carpentry, and waterplay.

The play leader speaks of the need for kindness in the environment. She explains that this means colorful, soft materials, comfortable, yielding furniture, and materials from nature.

She also stresses the importance of every patient's need to create something to give someone, <u>especially</u> if they are limited in what they are able to do. She teaches paraplegics step by step to use what little hand or foot control they have to make something. "What it means to someone who has had to lie in bed year after year saying 'thank you' to others to at last be able to make someone say 'thank you' to him for a present!"

The playroom has two child-sized kitchens ... one for pretend, one for real. In the real kitchen, children don chef's caps and aprons. Visitors are often greeted by a parade of these chefs, appropriately garbed, bearing a fancy bundt cake or a platter of cookies. When there is no company, they make parties for the porters and orderlies.

In the clinic waiting areas, where tension can build as anxious mothers wait with anxious children, toys permit both parent and child to relax. Children are encouraged to take a toy from the waiting area in with them while they see the doctor. This also helps medical staff members establish quick rapport by relating to the child through the toy.

HOLLAND

QUEEN WILHELMINA HOSPITAL, UTRECHT

Utrecht is a medieval city. The University was founded there in 1600. I visited the Queen Wilhelmina Children's Hospital there, escorted through the program by one of the large staff of social psychologists who assist with the play program. He informed me that the model for play in use there was eclectic, employing behavior modification and operating from an experimental psychology framework in contrast to the University of Leiden hospital's program which is based on the work of Bowlby, Robertson and Anna Freud.

Regarding parent involvement with pediatric patients, the psychologist remarked that as play and play therapy are considered the domain of the staff of play therapists and social psychologists, parents, who tend to focus on the child and prevent him from playing, are not encouraged to stay around.

AMSTERDAM

At one hospital pediatric department in Amsterdam where I made a very brief night visit, I was told that rooming-in was attempted in hospitals throughout Holland in 1958 and abandoned as unsuccessful because Dutch mothers are too home oriented to spend the night in the hospital. Most deliveries still take place at home. "Besides," my informant added, "If you fill up the beds with parents, where will you put the children?"

UNIVERSITY OF LEIDEN

At the University of Leiden attachment is the underlying concern. A corps of 20 observatrices (including students) serve a population of 40 hospitalized children. These are credentialed teachers, usually women over 22 years of age selected on personal qualities from subjective observations by the health care teams. A further special two year course prepares them to become observatrices. Salaries are equal to those of teachers.

It is their job to encourage attachment and reduce the number of encounters the young children must experience. They keep the mother-child relationship going or substitute for the mother. They provide appropriate person-social stimulation including limiting the infants' contacts to a few meaningful ones. Observatrices coach parents regarding appropriate techniques in play and other assistance of their children. For example: parents are instructed not to immobilize their children for procedures or participate in tests and treatments. They are advised to visit babies at least three times a day. It is the belief here that these frequent short visits compensate for the mothers' not living-in.

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Mothers come after 10:00 A.M. They feed and play with their own child only and do not participate in bathing the child. If a mother needs help learning feeding techniques, she rooms-in a few days.

Observatrices look at the hospital situation through the child's eyes and intervene with their own specially skilled knowledge. "It is emotional suffering the child experiences in the hospital, and the role of the observatrice is to help prevent this," I was told.

The observatrice tries to get a total impression of the child. She (or he) keeps records on the child's reaction to treatments as she accompanies the child to each one. Potentially frightening experiences as well as other tests and treatments that the child is to face the next day are recorded and followed up with appropriate play preparation and support. Observations are relayed to the doctors. In preparing children for treatments, the observatrices use a doll, a bear, or the child himself to show what is going to happen. With older children, they elicit past experiences and then go over in detail the new experiences. A play hospital (a two room white box) with a ward and an operating room with dolls to scale representing parents, physicians, nurses, babies, is used along with masks, tubes, syringes and other paraphenalia. Children hold their own masks for anaesthesia as soon as they are old enough. "We prepare them to handle their feelings," was the observatrice's description of the procedure.

Each child spends one or two hours each day in the play room. There he has the opportunity to express anger and aggression with water and sand. Children may use messy play on the ward, but by and large, ward play is limited to the less boisterous activity. On the ten bed wards, most children are up and playing. Each child has a box of his own toys stored under his bed and a bed table to use for play. Tables and chairs are arranged in the center of the ward with games and an aquarium visible. Carts with special activities are wheeled daily onto the wards. An outside yard has packing boxes and climbing equipment.

Three workers are assigned to the ten bed isolation unit which has its own special play equipment.

The program was developed by Professor G.M.H. Veeneklaas in the early 1950's. Today, as nursing care becomes increasingly patient-centered and psychologically sophisticated there are some conflicts arising over the respective roles of the observatrice and the nursing staff. Because of the intensity of the involvement with the patients, there are occasional difficulties in keeping staff. Regular consultation with the psychologist plus regular group meetings are scheduled to deal with these problems. The Head Observatrice coordinates and teaches in the training program.

DAY CARE CENTERS

Although hospital connected day care centers were not the focus of this study, I could not help but be interested in such programs when I encountered them during my visits. Day care programs for staff children operate in England at Fulham and at Amersham. Stoke Mandeville had none. "Nurses are supposed to be nurturing people." the Matron Sister said. "What are we doing when we entice young mothers to leave their children to come care for someone else's?"

FULHAM (CHARING CROSS)

At Fulham Hospital in London, staff children share facilities and some parts of the daily program with children from the Child Development Day Care Center. When activities are suitable for the mixed group of handicapped and non-handicapped, the group gathers as a whole. Where the differences in abilities and interests make a total group experience inadvisable, they divide.

AMERSHAM

In place of the spinster married to her career is today's young nurse graduate, married and with a baby or two. At Amersham Matron Daniel has established a creche on the hospital grounds for the infants and children of these young women. She was forced by circumstances to provide child care because,

> "..... one day the inevitable happened: I had no theatre sister. No one, and we had surgery scheduled. I called all the women who had been working here in the theatre (operating room) earlier and begged each in turn to come help me. The answer was always the same ... 'I'd love to help you out, but I have no one to leave the baby with.' So I said, bring the baby here to me and I'll care for him"

That was the beginning of the creche where children are cared for four or five hours while mother works. If mother works at night, she may bring the children to play while she catches up with her sleep. The children enjoy their stay and mothers have more time for play and for concentrating on their families because less of their home-time energy is spent in continuous cooking and child care. Matron Daniel arranges four hour shifts for all her staff who have young children so that they will not deprive their children of adequate mothering.

Since the adoption of this plan, Miss Daniel said she has had less difficulty keeping a full staff with more than twenty young mothers sharing

shifts. The plan allows the hospital to use the recently trained nurse without diminishing her effectiveness as either nurse or mother.

SWEDEN

In Sweden, each hospital I visited offered day care for children of staff, but discouraged infant care. A common family plan for child care, I was told, is for each parent to carry one half-time job, share household and child rearing and use day care centers to cover any remaining time needed. Day care centers are plentiful, well staffed and well equipped.

DENMARK

I visited three hospital based centers in Denmark: one at Glostrup, one at Hillerød and one at Rigshospitalet.

Glostrup

Glostrup Day Center is houses in two low attractive buildings reached by way of a wooded walk across the hospital grounds. Infants and pre-school age children are housed in one building; the school agers in the other. In the infant and pre-school center, each room has its own color scheme and all the belongings of that room are colorcoded for easy identification. In addition, each child has his or her own symbol which is carried out on all his possessions in each area ... for eating, bathroom and sleeping areas. Small, child height portholes offer children glimpses, their own size, of the world outside. Toys are plentiful and beautiful. Innovative structures have been designed by a Finnish designer, Utti Lutker. One such storage unit has steps to allow a child to climb and sit while his shoes are put on and includes a series of low cubbies for the older children and higher storage space for the youngest. The whole edifice makes an attractive and efficient multi-purpose island in one of the anterooms.

Babies sleep outside year round in a line-up of blue wooden buggies hooded to keep off the snow and covered with infant size eiderdowns. Their mattresses are stored in a warming closet when not in use, so that they will sleep warm during the winter, too.

Much thought is devoted to maintaining good parent-child and staff-child relations. Frequent get-togethers take place at the school. The occasions are social rather than educational. The director has plans for a bistro area so that parents will linger when arriving and leaving, making the link between home and school even more associated with the parents.

Children still on the bottle get all their food requirements including formula for the parent to take home from the nursery school This is to allow continuity of quality and save parents time for more playtime with their children. The older children get only a snack of dark bread sandwiches at the end of the day in anticipation of their sharing dinner at

home with their family. Children breakfast at the Center at 8:30, have mid-morning salad, mid-afternoon juice and fruit. The older children have an exciting playground with many of the adventure "junk" materials so popular in Denmark. This includes a large row boat.

Hillerød

The day care center at Hillerød has, in addition to the many exciting and beautiful playthings for the infants and children, a special vehicle room for the use of parents in transporting their children to and from the center on their way to work. Many of the families who use the center live on the hospital grounds in apartments built for the use of staff members. The vehicle room features wooden wagons and buggies. A parent may leave his bicycle at the center at night, borrow a wagon and tuck his child or children in and trundle them home. Next day, children return in the wagon, Dad or Mother pick up their bikes and spin off to work.

The staff-child relationship is very good, and the atmosphere in the Centers is comfortable.

Pediatricians in Denmark stress the importance of keeping the mother-child couple together during the first years. Families get a child allowance every three months to support mothers and enable them to stay home. Mothers who work are more likely to bring someone into the home for the youngest babies during their first year, but infant care in the centers is booming, and I was told that the centers cannot keep up with the demand.

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CONCLUSION

Intractable Problems Considered

There are countries where the entire family moves in and sets up housekeeping when a member is hospitalized. This is more prevalent in underdeveloped countries than those with advanced medical technology where, since the days of Florence Nightingale, hospitals maintain control over patients' visitors and consider parents as visitors.

Parental belief in yielding responsibility for their child's support to the expert professional has become part of many cultures even as many concerned health professionals now recognize the importance of the parent for the child during the crisis of hospitalization. Hard as it once was to push parents out, it would now take heroic efforts on the part of the institution to turn around the parental diffidence and/or indifference that now exists.

Unfortunately hospitals still rely on the parent to decide whether or not to stay. That this decision cannot be fairly placed on the parent was dramatized in a survey conducted by several Swedish hospitals with differing visiting hours. Each family was asked what hours seemed most appropriate for them and each answered that the best hours were those in practice at the hospital where they had their family member.

Today, hospitals and professionals are called upon to see what they can and are obliged to do in order to serve their communities as centers of psychological as well as physical healing. The child's need for care and attention remains the same no matter how valid are the parents' reasons for leaving him.

Unless our institutions can promote caring and intimacy, bring families in and help them see how important they are to their individual members, we are threatened with a society of indifferent, uncaring people a generation from now.

It would appear that organizations of consumers assisted by professionals are the most effective agents for public education with regard to the necessary services parents should request of their institutions and the effective ways in which pressure can be applied in order to bring about the necessary changes. NAWCH in England and ACCH in Canada and the U.S. are good examples of such agencies.

Happily, the trend is toward increased family involvement. The mechanics and the good-will exist. The largest block remaining is that of community education and communication.

REFERENCES

England

Bowlby, John. Child Care & the Growth of Love, Pelican, 1965.

Brain, D.J. "Controlled Study of Mothers and Children in Hospital," British Medical Journal, 3 February, 1968, pp. 278-280.

Department of Health and Social Security, Welsh Office: Cathays Park, Cardiff CFI 3ND, England. Hospital Building Note #23 and Appendix E, Children's Ward, Published by Her Majesty's Stationery Office, 1964.

Department of Health and Social Security, Welsh Office: Cathays Park, Cardiff CFI 3ND, England. Hospital Facilities for Children, April 1971, Published by Her Majesty's Stationery Office.

Dicker, Kathleen. "Unrestricted Visiting in Children's Wards: How Is It Working Out?," Midwife and Health Visitor, 7:5:185, 1971.

Forbes, M. Prof. "Comparative Study of Fostering a Proxy Parental Relationship," Unpublished Study, Department of Archeology, Cambridge, University.

Harvey, Susan, and Hales-Tooke, Ann. Play in Hospital, Faber & Faber, 1973.

Howlett, M.R. "Accommodation for Mother In a Children's Hospital," (About Great Ormond Street) Hospital Management Supplies, Seven Oaks, 1971, 36:406:162.

MacLennan, W.S. "The Young Chronic Sick at Home and in Hospital," Health Bulletin, Edinburgh, 1972. 70:2:110.

National Nursery Examination Board, 90 Buckingham Place Road, London, S.W.1WOSX, England. "Nursery Nursing: Make Children Your Career."

National Association for Welfare of Children in Hospital. Coming into Hospital.

Noble, Eva. Play and the Sick Child, Farber, 1967.

Oswin, Maureen. The Empty House, Alan Lane, The Penguin Press, 1971.

The Platt Report, 1959. The Welfare of Children in Hospital, HMSO 49 High Holborn, London WC2.

Robertson, James. Young Children in Hospital, Tavistock, 1970.

Robertson, James. Hospitals & Children: A Parent's Eye View, Gollancz, 1962.

Stacey, Margaret; Dearden, Rosemary; Robinson, David; and Pill, Roisin. Hospitals, Children and Their Families, London: Rutledge and Kegan Paul, 1970.

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REFERENCES

Denmark

Junker, Karin S. Leko Teket: A Program for Training through Systematic Play Activity, Stockholm. 1971.

Junker, Karin S. Boel, Stockholm, 1972.

Junker, Karin S. The Child in the Glass Ball, Abdingdon Press, New York, 1961.

Junker, Karin S. Selective Attention in Infants and Consecutive Communicative Behavior, Almquist and Wiksell, Stockholm, 1972.

Sweden

Lagercrantz, Rutger, M.D., and Groth, Carl G., M.D., Departments of Pediatrics and Surgery, Karolinska Institutet, Stockholm. Essentials of the Swedish National Program for Preventive Child Care, Issued by the National Board of Health and Welfare, 1971.

Holland

Bunyard, Peter. "In Urgent Need of Attention," World Medicine, March 24, 1971.

00072

REFERENCES

Children's Books

Dalstrom, Lean and Gydal, Monica. Ola Kommer till sjukhaus, (Ola Comes To The Hospital), Karolinska Institute, Stockholm, Sweden.

Dyrløv, Kirsten, R.N. et al. Per og Lise Har Sukkersyge. (Per and Lise Have Diabetes), Brochure from Glostrup Community Hospital, Glostrup, Denmark.

Jones, Anthony. Dan Berry Goes to Hospital, Chatto & Windus, 1967.

Ladybird Books. The Nurse.

National Association for the Welfare of Children in Hospitals. Simon Goes to the Hospital.

Rayner, Clare. What Happens in Hospital, Hart Davis.

Rey, M. & H.A. Zozo Goes to the Hospital, Chatto & Windus, 1967.

Films

Details for ordering films from Concord Films Council: Nacton, Ipswich, Suffolk in England.

Robertson's films are also obtainable in U.S.A. through: New York University
Film Library
26 Washington Place
New York, New York

Outlook, BBC-2. "Your Child in Hospital."

Lowenstein, H. & MacCarthy, Dr. "Parents and Staff in a Children's Ward."

Lowenstein, H. & MacCarthy, Dr. "Separation and Reunions."

Scrutiny, BBC-1. "Children in Hospital."

James Robertson's Films on Brief Separation: "John"
"Jane"
"Thomas"
"Kate"
"Lucy"

Hardgrove, C. "Care Through Parent: Creating Space in Pediatrics," University of California Extension Media Center, 2223 Fulton Street, Berkeley, Ca. 94720.

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